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IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BUNDABERG

..DATE 05/07/2005

..DAY 18





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THE COMMISSION RESUMED AT 10.02 A.M.

COMMISSIONER: Just before you start, Mr Atkinson, Ms Feeney?

MS FEENEY: Yes, Commissioner.

COMMISSIONER: We have received your letter. My understanding of the situation is that if your client Mr Leck wants to sue me, the Crown solicitor's office will be handling the matter and you can canvass with them issues of service and abridgement of time.

MS FEENEY: Thank you, Commissioner.

COMMISSIONER: That then leaves the question of what we're supposed to do while waiting for your client to bring his application. All your letter tells us is that he seeks to have me restrained from further proceeding in the inquiry. So what are we supposed to do in the meantime?

MS FEENEY: I understand that's a matter for you, Commissioner.

COMMISSIONER: Well, what are your submissions?

MS FEENEY: My submission is that proceedings should not continue.

COMMISSIONER: Should not continue.

MS FEENEY: Pending - from the time that the application is filed, but the application has not yet been filed.

COMMISSIONER: So, what, we keep going until your client gets around to filing an application and then we stop; is that the proposal?

MS FEENEY: That would be my submission, Commissioner, yes.

COMMISSIONER: What's the basis of that submission?

MS FEENEY: That it would be inappropriate to continue while an application for restraint and injunction is pending.

COMMISSIONER: Are you seeking then an interlocutory injunction?

MS FEENEY: Not at this stage.

COMMISSIONER: So your client doesn't want to get an injunction to stop us proceeding, but he wants us to stop of our own volition?

MS FEENEY: My instructions are not to obtain an interlocutory injunction at this stage.

COMMISSIONER: Can you help me with this? I'm afraid I'm mystified as to why we should stop of our own volition when you are not going to apply for an interlocutory injunction.

MS FEENEY: I'm unable to assist you, Commissioner.

COMMISSIONER: Does anyone else have any submissions about this?

MR DIEHM: Commissioner, as I informed Mr Andrews yesterday, it is Dr Keating's intention to make an application the same as Mr Leck's.

COMMISSIONER: Yes.

MR DIEHM: Commissioner, it seems as though the practice in these circumstances in inquiries such as these has been for the commissions to continue until such time that there is an order made otherwise.

COMMISSIONER: I know that was what happened in Connolly Ryan. I'm not sure that one instance creates a practice, but yes.

MR DIEHM: Commissioner, my client doesn't seek that the inquiry doesn't sit now or at the time of filing the application. That is not said in diminishment of his position or whoever makes the application, but it is in recognition that until such time as an order is made by the Court that the inquiry is reasonable - it is reasonable for the inquiry to continue. That is also made - a submission made in the contemplation that the matter will be resolved long before the inquiry is due to be completed.

COMMISSIONER: But the problem with that, Mr Diehm, is that we're spending - I mean, everyone here, I think, with the exception of the Nursing Union and the AMA is here at the public expense. We're spending tens of thousands, probably even more than that, of dollars each day and if Mr Leck or, indeed, your client thinks this whole commission should be closed down all that money is wasted.

MR DIEHM: Yes. Commissioner, may I say that if the Commissioners were of the view that this application is threatened, and if I can use that term advisedly, but proposed to be made that the inquiry be adjourned in the meantime, that is not a proposition that my client would resist, it is simply one that he has not instructed me to urge upon the Commissioners.

COMMISSIONER: That makes it extremely difficult because I don't know what the basis of your application is. You know, there was a complaint by Mr Ashton over a month ago about my conduct which he described as unfair, unnecessary and unexplained. That was over a month ago. I don't know whether that's the basis or there's something else that seems to be the basis; whether it's a combination of circumstances. So how can I adjourn it. Whether there is any merit in the application - I'm not saying there isn't - how, if there is

any merit in it and, therefore, whether or not we should cease sitting, unless I know what it's all about?

MR DIEHM: Commissioner, that is a matter which, of course, might be addressed at the time of service of the material which is contemplated, as I understand it, by Wednesday.

COMMISSIONER: Tomorrow. And what relief would your client be seeking?

MR DIEHM: A declaration and an injunction.

COMMISSIONER: And injunction to restrain what?

MR DIEHM: The further proceeding of the inquiry.

COMMISSIONER: On any issues?

MR DIEHM: Commissioner, it is certainly something that is open to be considered and my client, through his legal advisors, has been giving consideration as to whether or not the scope may, indeed, be more limited than that.

COMMISSIONER: Yes.

MR DIEHM: So that as it, for instance, involves a restraint only with respect to matters that pertain to the applicant.

COMMISSIONER: Yes. Because if that were the case, I mean, one solution - you know, the last thing we want to do is not - not only consign to a waste paper bin all the work that's been done, but to disappoint everyone who has hoped to come here and give evidence and get these things off their chests. One solution would be if - if there were a substantial case for bias or something of that nature, would be simply to say, well, we will make no findings with respect to your client, adverse findings. We might not say nice things about him; we won't make adverse findings. If there are matters to be advised to the CMC, they can consider them in their own time and their own way. Would that address your client's concerns?

MR DIEHM: I would expect it would be. Obviously the terms would have to be considered, instructions taken, but in all likelihood I would think that would be satisfactory.

COMMISSIONER: What about you, Ms Feeney?

MS FEENEY: Similarly, we would consider the terms and I will take instructions.

COMMISSIONER: I think you had better take those instructions then. Stand down for, what, half an hour?

MR DIEHM: Thank you.

MS FEENEY: Thank you, Commissioner.

THE COMMISSION ADJOURNED AT 10.11 A.M.

THE COMMISSION RESUMED AT 10.49 A.M.

COMMISSIONER: Mr Mullins?

MR MULLINS: Commissioner, before the discussion proceeds any further can I put a few matters forward on behalf of the patients.

COMMISSIONER: Certainly, although I will make it clear that I don't intend to make any decision today. I think everyone should have an opportunity to make submissions, Mr Boddice, Mr Devlin, Mr MacSporran, and yourself and, any of the other parties who want to be heard. So depending on what instructions are forthcoming I would expect to, as it were, adjourn this issue until Thursday, so that everyone has an opportunity to consider and make full submissions at that time. Having said that, if there's something you feel a need to say now, by all means do so.

MR MULLINS: Just two matters. Firstly, I only became aware, myself, of the potential application this morning.

COMMISSIONER: Yes.

MR MULLINS: And the patients only became aware that there may be an application when you mentioned it when the Commission opened this morning. Could I ask that the letter that the commission referred to be tendered in evidence, and if it's not - if it's not a lengthy letter to have it read out so the patients sitting within the Commission can hear what the letter said.

COMMISSIONER: I think that's a perfectly reasonable request. Ms Feeney's letter of the 4th of July 2005 to the Secretary of the Commission of Inquiry will be Exhibit 127.

ADMITTED AND MARKED "EXHIBIT 127"

COMMISSIONER: I will ask the secretary in a moment to make photocopies so that everyone has it available. I have made notes on my copy, so we will have a clean copy for them. Yes, and your other point?

MR MULLINS: The second matter was simply this: to put on the record on behalf of the patients that destabilisation of the inquiry is, obviously, a very significant matter for them. If there is an application to, effectively, derail the inquiry I'm instructed that the parties must recognise - the patients submit that the parties must recognise that to destabilise the inquiry will only cause more grief to those people who have suffered and one need only look as far as Judy Kemps, Ian Fleming and Linda Parsons who have already given evidence and

the impact the destabilisation of the inquiry will have upon them. They ask if the application is to proceed that the parties bring that application and deal with it expeditiously.

COMMISSIONER: Thank you, Mr Mullins. I am, of course, very sympathetic with everything you say, but I recognise Mr Keating and Mr Leck also have rights and they have signalled that they wish to have those rights explored in the Supreme Court, and I wouldn't want to be taken as discouraging them from seeking judicial review of my conduct, if that's their position. I would join with you in urging them that any such review take place quickly, and I don't know why it's been left until now, but that's a matter for them and, ultimately, for the Supreme Court.

MR MULLINS: Thank you, Commissioner.

COMMISSIONER: Mr Devlin?

MR DEVLIN: May I rise on one matter also, Commissioner, germane to the matters referred to by Mr Mullins. Yesterday the lawyers representing the Medical Board of Queensland met and advised the Medical Board to appoint an investigator as soon as possible under its own legislation using Dr Woodruff's report as a basis upon which to go forward on specific clinical cases. The Medical Board was due to meet next Tuesday at its normal meeting to formally appoint an investigator. It has - on receipt of the word that this inquiry may be delayed, it has put in train steps to appoint the investigator today and the ordinary form of investigation of clinical cases will proceed, and any consultation with the Commission - if it's thought that the Medical Board's investigations might cut across the work of the Commission, obviously I would consult with counsel assisting if I thought that was going to happen, but in the event that this inquiry is delayed, even for some days, the Medical Board is expected to resolve to proceed with what investigations it can without interfering with the work of this inquiry.

COMMISSIONER: Thank you, Mr Devlin, for informing us of that. It sounds to me that what is proposed is a useful exercise, in any event, and if the inquiry were to be delayed or, at least, stopped in its tracks all the better that the Medical Board is taking a responsible course at this stage.

MR DEVLIN: Yes, thank you.

COMMISSIONER: Thank you. Ms Feeney?

MS FEENEY: Commissioner, I'm unable to obtain instructions until I have had the opportunity to confer with counsel. Neither of my counsel are available. I ask that we stand down until after lunch to be given the opportunity to confer.

COMMISSIONER: Well, I will hear what Mr Diehm has to say here.

MR DIEHM: Commissioner, I am also not in a position to take

up the proposition that is proposed, I must say, in the time with reflection.

COMMISSIONER: That's understandable.

MR DIEHM: Commissioner, the only other thing that concerned me and, unfortunately, I don't have a copy of Justice Thomas' decision here with me, but I had thought it may have been the case that whilst the practice was, as I intimated and you acknowledged, practice for one case in the Connolly Ryan situation, that the inquiry proceeded there, that there may have been some adverse criticism of the Commissioners for doing so by Justice Thomas.

COMMISSIONER: My recollection is that's not so. There were questions raised as to whether an interim arrangement put in place by the chairman of that inquiry, Justice Connolly, to allow Justice Ryan to proceed and hear issues that didn't affect the proceedings, that process was held by the Supreme Court to be ineffectual, I think. It was put in terms of you can't unscramble the egg, and that's something we all have to take on board, but my recollection is there's no criticism, in fact, that the inquiry continued to hear evidence pending the outcome of the Supreme Court proceedings. Mr Devlin, do you have a recollection one way or the other?

MR DEVLIN: I think it turned on the fact that Mr Connolly continued to play a role in administrative affairs, that Mr Ryan - Dr Ryan - gave a, and I'm reading from the judgment, ruling, in effect, that he could continue without taking any step which might reflect upon the reputation or position of Mr Carruthers in any way, and Justice Thomas observed, "In the days following Dr Ryan seems to have encountered some difficulty giving effect to this intended exclusion of evidence affecting Mr Carruthers' cross-examination adduced matters touching and concerning Mr Carruthers conduct", et cetera. So the Court referred to the difficulties which followed when Dr Ryan did attempt to unscramble the egg.

COMMISSIONER: Yes, and that's why - I mean, one of the thoughts that crossed my mind is whether it seems - it seems the criticism seems to be directed only to me. Whether I can stand down and let the two deputies deal with these matters, but these are the very problems that arose in Connolly Ryan which is why I suggested that the appropriate outcome would be, if it were established that there was bias, the appropriate outcome would be none of us deal with issues in terms of findings adverse to Mr Leck or Mr Keating and that those matters go off to an entirely independent body, namely, the Crime and Misconduct Commission. That's just one possibility.

MR DEVLIN: The difficulty might be to go back to the terms of reference, and whether the terms of reference can be carried out in those circumstances, and that requires a lot of thought.

COMMISSIONER: It shouldn't be a great deal, frankly, but we

will look at that. What I propose to do is to defer consideration of this issue until Thursday at 9.30. At that time I will hear any application by either Mr Leck's or Mr - Dr Keating's representatives as to whether I need to disqualify myself either entirely or in part and any submissions as to what should occur in relation to the balance of issues, if I am persuaded that I should disqualify myself, whether the proceedings should continue pending the foreshadowed application in the Supreme Court or whether it's appropriate to adopt the sort of outcome that I foreshadowed earlier, which is that issues relating to Dr Keating and Mr Leck will not result in any adverse findings from this inquiry and that other appropriate bodies, such as the Crime and Misconduct Commission, can deal with matters as they deem fit. So that will be dealt with at 9.30 on Thursday and in the meantime we can go ahead with the evidence.

MR MULLINS: Commissioner, just one further matter, if I might raise it.

COMMISSIONER: Yes.

MR MULLINS: Just the issue of the adverse findings, I am afraid that I have some difficulty in comprehending what that proposal is. There seem to me to be three levels of adverse finding. One level is a recommendation, for example, of criminal charges-----

COMMISSIONER: Yes.

MR MULLINS: -----that might follow. The second level of adverse finding is some adverse factual finding and some critical comment in a qualitative sense. For example, the conduct in respect of an incompetent medical practitioner without recommendation of criminal charges. The third adverse finding might be a finding against a witness where there was a conflict of evidence. So, for example, the easiest case that comes to mind is there might be some conflict between what Mr Fleming said occurred during his conversation with Dr Keating in respect of his complaint. If the Commission is proposing - I am not saying it is a proposal; it has been floated - that there be no adverse findings and the adverse findings go as far as the second and third of those options, in particular the third of the options, if the Commission was going to say, "Well, we're not going to resolve the conflict or try to resolve the conflict of evidence between Dr Keating and some other witness", that would effectively emasculate the findings of the inquiry, if that's what's proposed in terms of no adverse findings or is it the first or the second?

COMMISSIONER: The simple proposal is that the report would not contain a word - this is all on the assumption that a case is made out of a reasonable apprehension of bias - the report would not contain one word to discredit either Dr Keating or Mr Leck. That would clearly cover your first and second categories.

As regards the third category, I don't see any reason which would prevent us from saying, "We accept the evidence of Mr Fleming", for example, if that were the conclusion we arrived at, without needing to go into any further than that and say why we reject any contrary evidence on the part of Dr Keating. So anyone reading the report - I mean, as I understand the law, the interest that Dr Keating and Mr Leck have is that we don't prosecute anyone, we don't try or convict anyone. All we do is say things in a report and no-one looking at the report would see anything in there critical of either of those individuals. And it may be the situation, to take one example just because she is represented here, but Mrs Mulligan, it may be that if there were anything critical of her - and so far I don't think there is any evidence that could be classed as raising any ultimate issues of criticism on her part - but if there were anything critical of her, and her answer was to say, "Well, I passed it up the line to the appropriate people", again, it wouldn't then be necessary to canvass whether those appropriate people dealt with the matter in the right way or the wrong way. It would be a complete answer on her part to say she passed them up the line to the people who were appropriate.

So I value your input but I don't think it is as much of a problem as you seem to feel it might be.

MR MULLINS: Thank you.

COMMISSIONER: Unless anyone else wants to raise anything, we will deal with those issues at 9.30 on Thursday. Yes, Mr Devlin.

MR DEVLIN: The question is whether the evidence should proceed at all. My submission would be that it ought not.

COMMISSIONER: Why?

MR DEVLIN: Matters of details concerning the administration of the hospital will necessarily arise in virtually every witness that I am aware of who is to be called.

COMMISSIONER: Yes.

MR DEVLIN: The question is that whilst the matter is in this state, whether full and careful inquiry can occur until the matter of what one apprehends is some kind of challenge is resolved. I simply express that as a concern at this point in time as to whether evidence should proceed.

COMMISSIONER: Mr Devlin, the situation, as I see it, is this: all we've got at this stage is a letter from Ms Feeney and a verbal communication from Mr Diehm foreshadowing some sort of application. We don't know the basis of the application, let alone anything from which we could judge its merits. Those two very experienced lawyers have themselves informed me that there is no proposal to seek an interlocutory injunction restraining my proceeding, and no proceedings have actually been filed. It would strike me as utterly bizarre to say that just because a solicitor writes a letter, we down tools and wait and see what happens.

MR DEVLIN: The submission-----

COMMISSIONER: If and when we receive the application - for example, on its face there is a matter of substance that prevents us from going ahead, then I will review the matter. That's why I, as it were, raised that issue for hearing at the earliest opportunity. We're told we will have the application tomorrow, so 9.30 Thursday we will be in a position. In the meantime, I don't see why we should change one iota of the course of proceedings that we've been taking to date.

MR DEVLIN: I have made my submission.

COMMISSIONER: Thank you, Mr Devlin. Mr Atkinson?

MR ATKINSON: Thank you, Commissioner. Commissioners, it is proposed this morning to call two doctors to give evidence. The first is Dr Dieter Berens, and he is an anaesthetist with the Bundaberg Base Hospital. He is called, of course, to give evidence in relation to the oesophagectomy to Mr Kemps.

COMMISSIONER: Yes.

MR ATKINSON: The second doctor proposed to be called is Dr Dawid Smalberger, and he is a physician with the Bundaberg Base Hospital. He is called, admittedly out of sequence, for this reason: he sees Mr Kemps when he initially comes to the hospital and diagnoses the problem and recommends transfer to Brisbane, but, if I may, I call Dr Dieter Berens.

COMMISSIONER: Thank you.

MR BODDICE: We seek leave to represent Dr Berens.

COMMISSIONER: Yes, you have that leave. Dr Berens, would you come forward to the witness-box?

DIETER BERENS, SWORN AND EXAMINED:

MR ATKINSON: Witness, would you give the Commission your full name?-- Dieter Berens.

And you are a doctor at the Bundaberg Base Hospital?-- That's right.

Dr Berens, have you provided a statement of your evidence to the Commission?-- That's right.

Can I show you the original of that statement?-- Yes, please.

Did you bring a copy with you, Dr Berens?-- A copy which I - not latest edition, no.

If you look at that document before you, is that your name and handwriting?-- That's right.

That's the statement that you provided to the Commission?-- That's true.

Are the contents of that document still true and correct to the best of your knowledge?-- That's true.

Dr Berens, could I just walk you through that statement?-- Yep.

In paragraph 2 you explain that you were employed as a staff specialist in the Anaesthetics Department of the Bundaberg Base Hospital?-- Yes.

You report to Dr Martin Carter?-- Yep.

You set out your qualifications in paragraph 3 and 4. Effectively you are qualified as an anaesthetist in your country of origin, South Africa?-- That's true.

And you have also completed a specialist exam for overseas-trained doctors in Australia?-- That's true.

Now, in terms of your work history in Australia, you worked at Mt Isa, then Bundaberg, then Ipswich, then Hervey Bay and you started again in Bundaberg on 1st of January 2004?-- That's right. Not 1st of January, a bit later. Beginning of January, that's right, yep.

If I can take you then to paragraph 6, and you speak there about some general misgivings you had about Dr Patel?-- Yeah.

Could you explain those to the court?-- The first time I had misgiving with Dr Patel was about a patient which I felt shouldn't have got blood which he ordered and that was basically the first misgiving we had.

And is that the one that was an issue that you raised with Dr Patel?-- That's right.

Is that the same issue to which you refer in paragraph 8 of your statement?-- Yeah, same issue.

So you raised the issue with Dr Patel and you asked him to show you evidence for taking the particular clinical course that he had taken?-- Yes.

And he told you he didn't need to show you any evidence?-- That's right.

Now, subsequently, I understand you were called to Dr Keating's office?-- That's right.

Can you tell us about that meeting?-- Dr Keating basically asked me that he has been informed that me and Dr Patel had problems during the weekend, and he basically asked me to tell him what it was all about, and I gave him basically a rundown about that, and Dr Keating said that he felt this is a clinical problem and we are both professionals, that we should actually solve these problems ourselves. And he expected us basically to do - you know, solve those problems.

And that was the end of the matter, as far as you were concerned?-- Yeah, that was the end of the matter.

Did you go back to Dr Patel to discuss further your clinical concerns?-- Dr Patel evaded me during that period of time. He basically ignored me when I greeted him, so - and that lasted some days.

Before the frostiness thawed?-- Excuse me?

Before the frostiness on Dr Patel's part thawed?-- Yeah, yeah, which, under those circumstances, working - needing to work as a team, I went to Dr Carter and told him about the problem which we had during the weekend and Dr Carter then came about and we had a meeting then together. The surgeons and me and - yeah.

In paragraph 7 of your statement, you talk about anastomosis?-- That's right.

Is that the way you pronounce that word?-- That's correctly pronounced.

That's when you stitch a bowel together?-- Yeah.

You mention in that paragraph that there was one operation you were involved in where you considered that there was a leakage of the bowel subsequently?-- I wasn't involved in the operation so much, I was involved in the post-operative care. This patient was in the intensive care unit and he was deteriorating in intensive care, which is a sign that he had also signs of infection, and also drains basically, which are put in to - so if there is anything else wrong, they show also that there is a leakage somewhere. But the most likely case would be that it is coming from the anastomosis.

So what happened in that case?-- Dr Patel wasn't real keen, basically, to reoperate on this patient and he then, after much discussion, said he is going to have second opinion. He got a second opinion from Dr Pitre Anderson, the surgeon.

As a result, did Dr Patel reoperate?-- Yes, he did.

Now, did he conduct the operation as if there was a problem that amounted to a leakage at the anastomosis?-- Yeah, that's right.

What did he say about the possibility that it was a leak to the bowel?-- He said basically he couldn't find where it comes from, he doesn't know where it comes from, where the leak comes from, but he was conducting the operation as if it came from the anastomosis.

Now, in paragraph 10 of your statement, doctor, you say that you have been a little wary in your dealings with Dr Patel. Am I to understand that to mean that you found sometimes there was a discrepancy between what he said or what his records said on the one hand, and on the other hand the patient's underlying pathology?-- No, I couldn't from that time actually pinpoint any patient where that has been the case, but if you experience something like that, if a patient or a surgeon is not totally true about what he says, then you have always got it in the back of your minds.

D COMMISSIONER VIDER: Could I just ask a clarifying question? This patient we're talking about with the leaking anastomosis, you were not the anaesthetist, you were in intensive care?-- That's right.

When the patient went to the - went back to the operating theatre, did the surgical record state that the operation that had been performed was the reanastomosis of the bowel?-- No, I was actually in the theatre present.

Do you know what was written on the operation record?-- No, I don't.

Thank you.

MR ATKINSON: In a nutshell, your concern about that - the doctor's behaviour on that occasion was that whereas he was saying, "I don't know where the leak is coming from", he conducted the operation entirely as if he was suturing a bowel?-- That's true.

Now, in paragraph 11 you talk about the ICU and you mention there, Dr Berens, that right from the beginning of your time at Bundaberg Base, which, of course, was early January 2004, you were conscious that there was tension between the ICU and Dr Patel?-- That's right.

Could you tell the Commission a little more about what you observed in terms of tension?-- Well, in general, the staff wasn't very happy about Dr Patel, specially not being happy to transfer patients when it seems to be necessary to transfer the patients, and that the staff also basically mentions that they - if they ever are going to be sick or needed an operation, then please don't have Dr Patel do the operation.

And you - those things were said directly to you or you were within the presence of others when that was a conversation going on?-- No, that was directly to me, yeah.

You also mention that you were well aware that Dr Miach and Dr Patel weren't getting on well?-- Yeah, that I heard just second or third or fourth hand, basically, that with any patient who needs fistulas or they have got blood in their fistulas, and so on, then they need operation, he never was successful. Also Dr Patel mentioned once he doesn't get on with Dr Miach either. He says he is an arrogant man.

So you understood on the grapevine, as you say, that Dr Miach wouldn't allow Dr Patel to do the fistulas for the renal work?-- Oh, yeah, prefer to have them done, yeah.

Can you say the extent to which that was common knowledge through the hospital?-- That I don't know. I mean, yeah, I heard it from second, third sources, so I assume other people would know that also.

Can you say, in your experience as an anaesthetist, whether ICU was being used too much or was being used to do operations outside its scope of practice during Dr Patel's term?-- Yeah, I would say - I mean, it is a level 1 ICU, and according to guidelines they should have just - they are different guidelines but patients shouldn't be ventilated - there

shouldn't be more than two patients or more than one patient ventilated, and they should be ventilated for 48 hours at a maximum, and which didn't really occur.

Can I break that down a little bit, doctor? The first issue is that there is some controversy about whether it is an ICU 1 or 2?-- Yeah.

And you may be aware that during Ms Hoffman's evidence we saw the guidelines from the joint faculty. Can you say whether - why you say it is a level 1 hospital - level 1 ICU, I should say?-- I must say I didn't follow the guidelines. I didn't follow that. I haven't seen that.

All right. Well, maybe I should phrase that differently. By pegging it yourself that level 1, I understand you to say that-----?-- I personally see as a level 1 that you maximally ventilate a patient for 48 hours and then the patient has to be sent to another intensive care unit, so you stabilise and then you send the patient to another intensive care unit.

Your view - is this right, doctor - that it only just made level 1?-- Yeah.

And why is that?-- Sorry, can you-----

COMMISSIONER: Is there a level below level 1?-- I don't know anything about a level below - ICU, the lowest level is level 1, as far as I know.

And I guess you can have - within these levels there is a certain range. You might have an ICU that's at the bottom of level 1 or at the top of level 1, almost good enough to be level 2. Do you know where this fell within the range?-- As it has been used in Bundaberg Hospital, it ranged to become a level 2 type of unit.

So Dr Patel was using it as if it were a level 2?-- That's right.

But from your knowledge, it wasn't that the equipment and staffing and resources were not good enough for that?-- As I was informed, yes.

And the usual thing then would be for patients to be transferred to another hospital that does have a better standard of ICU?-- That's correct.

And in your statement you say Dr Patel was reluctant to transfer patients?-- That's right.

D COMMISSIONER VIDER: We have heard evidence that in that level 1 classification the two cardinal points are the amount of time you keep a ventilated patient and the number of ventilated patients that you can have in the unit. Is that your understanding as well?-- Yes.

MR ATKINSON: Doctor, to continue on the ICU theme, can you

say whether or not, in your opinion as anaesthetist, the ICU was capable of providing the support post-operatively for oesophagectomies and the Whipple's procedure, for instance?-- If the surgeon is capable of any complications, the ICU would be able to handle the patients, yeah.

And in your experience was Dr Patel capable of handling complications?-- No.

No?-- Not oesophagectomies.

COMMISSIONER: Could you repeat that answer, please?-- I think Dr Patel wasn't capable of handling complications. The moment he had to open the thorax to do a thoracotomy, to open up the chest and work inside the chest cavity.

MR ATKINSON: The thoracotomy is the opening of the chest cavity?-- That's right.

Which is something that occurs in the course of an oesophagectomy?-- Yeah. In this patient you can do different operations but that's what included in the operation I have been involved with, yes.

Normally, just to explain it to people, the oesophagectomy you do two major procedures; a thoracotomy, so you can get to the oesophagus?-- That's correct.

And the laparotomy, so you can get to the stomach?-- That's correct.

You resect the two and join them back together?-- Yeah.

And then you put the chest and the stomach back together?-- Yeah, you close it, yep.

COMMISSIONER: Mr Atkinson, we're now getting on to the evidence about the late Mr Kemps. Mrs Kemps, who gave evidence on Friday, will obviously find this evidence very distressing and she has asked that she not be filmed or photographed whilst this evidence is taking place. So I would ask the camera monitors and any still photographers to respect Mrs Kemps' privacy hearing this distressing evidence. Thank you.

MR ATKINSON: Dr Berens, your evidence in relation to complicated procedures is that - is this right - the ICU only works properly with the surgeons if the surgeons have good insight into their own capabilities?-- That's true.

And is this also right: that your view was that Dr Patel lacked that insight?-- Yes.

Now, can I take you to the case of Mr Kemps? His code within the Commission is P21. Can you tell the Commission about your involvement in that procedure?-- I was anaesthetist for that procedure and I saw Mr Kemps - or P21, I saw him before the operation and I found him to be, from a functional point of

view, capable of handling the operation or being fit for the operation and we - he was then - first of all he was scheduled on Friday. There was no intensive care unit beds available so he was done then on the Monday. So the procedure was basically then conducted.

Can I take you to paragraph 15 of your statement? You say that Dr Patel diagnosed the man as suffering from cancer in his oesophagus, and then in the next sentence you mention, "Dr Patel maintained that he had less than a year to live."?-- That's right.

Can you say whether Dr Patel made it clear to you whether there had been any staging at that stage?-- No, we hadn't spoken about any staging.

At this stage, he has told you about cancer to the oesophagus. Was there any discussion about whether there might be a primary or a secondary tumour somewhere else within the body?-- I assumed that there have been secondaries also, because it is a palliative procedure, it is just to alleviate the patient's - or increase the quality of life of the patient, but it is not going to cure the patient.

But it is quite an invasive operation, we've heard?-- That's true.

And the aftermath can be quite painful for the patient?-- That's true.

Even if it goes well?-- Yes.

So you assisted as the anaesthetist in that operation?-- Yep.

And there wasn't any discussion, with you at least, about whether other alternative methods might be used to address the cancer?-- No.

Now, can you tell us about what happened then from the operation?-- The operation at the beginning went well. We had no problems. During the gastrectomy part and working in the thorax, the patient suddenly became unstable, meaning that the blood pressure dropped and the pulse rate came up, which is a sign of losing - most likely losing blood. We had to give him extra fluids, and there was also more blood coming with - usually the blood is suctioned away when it happens. More blood was suctioned away and there was also more sponges been asked for.

COMMISSIONER: More sponges, did you say?-- Drapes, or whatever they use to drape or make the operation side visible.

When you noticed the blood pressure dropping, did you tell Dr Patel about that?-- Yes, I told him about that.

Yes.

MR ATKINSON: So that there was a lot of sponges being used?--

Swabs, yeah.

And did you find the source of the bleeding?-- No, it seemed to stop. I mean, the patient stabilised again and so the operation continued.

D COMMISSIONER VIDER: This part of the - the dropping of the blood pressure had commenced and the bleeding had commenced when you were still working in the abdominal section?-- That's right.

MR ATKINSON: Then what happened, doctor?-- Then the abdominal part was finished from the surgeon and the patient was then repositioned for - to open up the chest cavity and then the operation went ahead. Dr Patel resected the tumour in the chest. During that period of time the patient also became unstable during certain times, but it was apparent to me that Dr Patel was not destined to work in the chest. Needs somebody with experience, really, working the chest to know what he was doing.

What signs were there that he wasn't competent doing chest work?-- Well, if you handle tissue in the chest roughly or not be aware, then you get blood pressure drops - actually, that doesn't need to have any blood loss - and you also get what we call dysrhythmias on the ECG, or changes of heart rate, which occurred quite often while Dr Patel was working in the chest, and that wasn't really accompanied by blood loss. It is just roughness of handling. The heart is there and the big vessels are there. When they are handled like that and the structures that you get these type of signs.

The dysrhythmia is a sign of poor surgical handling?-- It can be, yes.

And that's really a list of the reasons why you thought that he didn't have much experience or at least competency in thorax work?-- Yeah, and he wasn't interested also in what happened at my end basically usually a thorosurgeon works quite closely with the anaesthetist and are interested in what happens on the monitoring side or to see what is actually the blood pressure and so on, and he wasn't really interested in that.

Now, was there blood loss at this stage?-- It was continual but it was not that over and above what you would expect.

All right.

D COMMISSIONER EDWARDS: Blood loss was from-----?-- In the chest while you were working in the chest as well.

As well? As well as the operation in the chest as well as what was leaking out through the tubes?-- No, this was not something leaking really out of the tubes, the drainage has been put into the abdomen but at this stage there was no active drainage as such, it was draining a bit but-----

Within normal limits?-- Yep.

MR ATKINSON: So there's steady blood loss but nothing that seemed clinically significant for that operation?-- Yeah, there's just from my point of view also we needed to give and we needed to start to give blood during that period of time because the red blood cells started to fall or the yeah, the count of the red blood cell started to fall and so we needed to start to give blood actively, yes.

And then you mention in paragraph 17 that there was a bleeder?-- Yeah, that's when it became quite apparent when we turned the patient back on to his - the chest was where it was done, it was closed and we turned the patient back on to his - into the normal position lying on his back and then with that, the blood pressure dropped again which is also a sign of there is some volume loss-----

And could you see the volume loss?-- -----and then blood came out of the drains quite rapidly, yes.

D COMMISSIONER EDWARDS: At that stage?-- At that stage, yes.

For the first time?-- Well, during that period of time it wasn't dramatic, the blood came out but not that you can say that it's significant, but the moment he was turned, maybe due to the drains now going to - the blood got into contact with the drains now suddenly the blood came out.

Yes.

MR ATKINSON: And at this stage, doctor, is this right, you're

seeing blood loss that isn't normal for this procedure?-- That's correct.

So what happens at that point?-- Well, we kept on giving blood to the patient and try to stabilise blood pressure or did stabilise the blood pressure and made Dr Patel aware that this is a bleeder, there's active bleeding inside the cavity.

D COMMISSIONER VIDER: And the patient left the operating theatre with the surgeon being informed that there appeared to be active bleeding?-- That's correct.

MR ATKINSON: Who left first? Well, keep it chronologically if you will, doctor: so the surgeon's been informed that there's this bleeding, you can see the blood loss in the drains?-- Yes.

What does Dr Patel do?-- No, Dr Patel, he was aware - made aware by everybody basically that it's quite obvious he - there is active bleeding going on in the abdominal cavity and he just looked at it and he said, "It doesn't need opening of the abdomen at this stage."

And is that an irregular response in your experience?-- No.

So-----

COMMISSIONER: Sorry, when you say it's not an irregular, I think there might have been some misunderstanding; is that the response you would have expected?-- No, it's irregular response, it's not a regular response, no.

Yes.

MR ATKINSON: Thank you Commissioner. So the patient's still bleeding. Dr Patel has said to you that he doesn't intend to re-open the abdominal cavity?-- That's correct.

Does Dr Patel stay in the theatre?-- No, no, he went out and it was a decision basically no, he's not going to open the cavity as such, the abdominal cavity he doesn't think - well, basically he must have thought or his opinion must have been that there is no bleeder, he didn't agree with that.

COMMISSIONER: Doctor, the amount of blood that was apparent to you, was that consistent with having, for example, struck a major artery, were you able to indicate to us the extent of damage necessary to produce that amount of blood?-- I would say an artery, I wouldn't say a major artery because the blood pressure would have dropped much more dramatically if it was a major artery.

All right, and the degree of blood loss that you were observing, what implications did that have for the patient if it wasn't repaired?-- That he would die, that's certain.

MR ATKINSON: It was consistent, was this right, with perforation of the oesophagectomy or vessels, the blood

loss?-- It could be.

It could be from a number of things?-- Yeah, it could be from a number of sources.

So-----

COMMISSIONER: But is it as simple as this: that the level of blood you saw indicated that if that patient didn't receive further treatment, he would inevitably die?-- Yes.

And Dr Patel simply left the operating theatre doing nothing about it?-- Yes.

Who else was present?-- The nursing staff, yeah, the nursing staff and anaesthetic nurse who assisted me.

Right. No assistant surgeon?-- There was an assistant surgeon, I can't recollect who it was.

MR ATKINSON: Can I suggest this to you, doctor, that it was Dr Sanji Kariyawasam, Dr Anthony Athanasiov and maybe also David Risson?-- Yeah, that may be true, yep.

And Commissioner, two of those people will be called in Brisbane and Dr Athanasiov will be called in Bundaberg.

COMMISSIONER: Yes.

MR ATKINSON: So Dr Patel leaves with the patient still in theatre?-- That's correct.

And the junior doctors were left to complete the operation?-- No, I think the operation has been completed at that stage. I mean, because he, Dr Patel, basically closed the chest cavity, the laparotomy was done already, the patient was just turned and was now ready actually to go to the ICU as normal procedure but now we've got the problem of the patient is actually bleeding.

So the patient is taken to ICU bleeding internally?-- That's correct.

And Dr Patel, is this right, he goes to do another operation?-- That's correct.

So he's not doing any monitoring of the patient?-- Well, it's our responsibility to once the patient goes back basically to the ICU or joint responsibility.

Whilst he's in the ICU, are you monitoring his progress?-- That's right.

And can you tell us whether or not you were giving the patient blood products?-- Yeah, we had to give him, the patient multiple blood products, yeah, to keep his red blood cell volume at an accepted level and also that he keeps on clotting.

So you were giving him steady levels of blood?-- That's right.

And something called Gelofusine?-- Yeah, that's to keep the volume up, yeah.

And something called four units of FFP?-- Yeah, that's so that the blood plug the holes yeah, to keep it thick, so to speak.

D COMMISSIONER VIDER: Dr Berens, did you see the surgeons report from this procedure? Did it indicate that the - that there was some active bleeding at the completion of this operation?-- I never read the report.

Well, what sort of a handover was given to the intensive care staff? Was it just a verbal handover?-- I don't know what the surgeon said to the intensive care staff, I don't know.

We've had evidence given to us before that Dr Patel's records are not what you might say fulsome in the details that they contain. I'm just wondering whether this would be another example of that where if you look at the surgeon's report, you might see something but it mightn't be the whole and complete picture which if you were doing an audit of the report wouldn't necessarily be a faithful record and enable an accurate assessment of what had gone on?-- That could be possible.

Thank you.

MR ATKINSON: Can I show you the two surgeon's reports and perhaps you can tell us whether you think they accurately record what happened in the operation. But actually Dr Berens, I'll ask you to put them to one side for a moment whilst we just complete the evidence?-- Yes.

So perhaps if they could be left on the desk there. Now, in the ICU you were administering the various blood products?-- That's correct.

And saline as well?-- That's right.

Now, in the meantime, Dr Patel's in another operation?-- That's true.

Is word getting to Dr Patel about the progress of this particular patient?-- Yes.

And do you recall how that happened?-- Well, we just let Dr Patel know that this patient is still actively bleeding and that we have to give multiple different stores of blood products and fluid to keep him stable and we had also basically at that stage to start to support the heart with what we call inotropes to keep up the blood pressure.

And how long is Dr Patel occupied in the other operation?--

About four hours.

Now, is that usual conduct, that a doctor's occupied elsewhere when you have this level of blood loss?-- He started a operation where I heard secondhand, I wasn't there at the operation, that he had a complication. Usually the operation should have lasted him three quarters of an hour, an hour, but then because of that complication he had, it took him much longer.

So what becomes of the patient in ICU?-- Well, we kept basically his physiological functions as normal as possible and that's what happened.

Is he taken back to surgery?-- When Dr Patel was finished with the previous surgery, we took him back to theatre, yep.

So for four hours you're using the inotropes and various other means to maintain the blood pressure and the cell count?-- That's correct.

You're involved, Dr Berens, when Dr Patel takes the patient back to theatre?-- That's right.

Can you tell the Commission what happened when he went back?-- After putting the patient properly to sleep, we - Dr Patel opened then the abdominal cavity again and tried to locate the bleeder and that took quite a while and then he wasn't able to locate it and he felt that the bleeder must come actually from the chest cavity, so then the patient was turned again and the chest was opened again and he was then looking for the bleeder there and there was a lot of blood coming out there but he couldn't locate the bleeder there when he was opening the chest cavity, it seemed that the bleeder was coming from the abdominal cavity, so in the end, he said basically, "I can't do anything", that's basically - and during the operation he suddenly scrubbed up, in other words, he left the theatre and said he had to speak to the family and then came back after a short period of time and continued and said, you know, he can't do anything for this patient.

So effectively he reached the conclusion that he couldn't find the bleeder and he couldn't try any longer?-- That's correct.

D COMMISSIONER VIDER: At any stage during these proceedings when Dr Patel reached a stage of saying he couldn't find the bleeder, did he contemplate getting some assistance from another surgeon?-- No.

Is that unusual in your experience?-- That is.

Yes. Thank you.

MR ATKINSON: Doctor, perhaps at this point I'll ask you to look at the surgical reports or the surgeon's reports you see before you. And I'm really interested in the Commissioner's question, whether you think that - or maybe it was Miss Vider's question - whether you think that the surgeon's report

really reflects what happened in the operation?-- Yeah, it doesn't mention anything about the bleeding afterwards, otherwise I suppose that's quite consistent with what has been done.

There's two surgeon's reports and you're looking at the first one no doubt because the second one does talk about a post-operative bleed, I think, but what you see from the first report is it just doesn't make mention to the bleeder that was found?-- It does mention in the stomach that oozing from pancreatic bed, packed five minutes, bleeding settled.", so it actually mentioned that there was bleeding while they were working there.

COMMISSIONER: But it doesn't mention the post-operative bleeding though, does it?-- No, it doesn't mention the post-operative bleeding at all.

So it's not complete, is it?-- No, it's not complete, no.

D COMMISSIONER VIDER: Dr Berens, one of the first principles followed in surgery is that the surgeon must create a good visual field of the area on which he wants to work. We've had evidence presented to us that would indicate that Dr Patel didn't always achieve that principle, in this person's opinion. I know that you were the anaesthetist, but if you can't locate the bleeder, then I'm wondering whether that's another indication of this first principle not being achieved, that there wasn't a good visual field?-- It could be.

Mmm.

D COMMISSIONER EDWARDS: Could I - sorry, ask you also, would it be a very unusual surgical incident in your experience that bleeding of this nature would be allowed to continue and the patient sent back to the ward?-- No, definitely not.

Thank you.

COMMISSIONER: Sorry again, there might be some confusion between usual and unusual. Are you saying that that is a common thing or not a common thing?-- No, it's uncommon.

Yes.

MR ATKINSON: Now, after this operation, the patient passed away?-- That's right.

Can you say how long after the second operation that occurred?-- About 12 hours.

Right. And effectively, he was managed very conservatively until his death?-- That's right.

All right. Now, can I show you this document? There's an overhead projector here doctor and I might have the document put up on to the projector. This is from the medical record, it's attached to your statement. Well, perhaps we can put it

straight on the projector this time. There's a screen right in front of you that should light up.

COMMISSIONER: And our screens haven't been turned on so I don't know if there's a control for that.

MR ATKINSON: Now, at the top half there you can see on your screen, doctor, that's Dr Patel's writing, isn't it?-- That's correct.

Can you read his handwriting?-- I saw that before and I can read up "Continue to bleed" and this word I can't interpret "drop of" and then I can't interpret what it says there, "BP in" and then I can't interpret what he's said there and then the next word I can't interpret, it's "sedated" and then "ventilator" and the "Plan" I can read basically, "No more transfusions, vasopressors or coagulation products. Family has accepted the outcome".

And then if I can ask you to go to the second half?-- That I can read clearly.

I think that's a lady's handwriting, it's much easier to read.

COMMISSIONER: Oh, you're in trouble now, Mr Atkinson.

MR ATKINSON: Now, the cause of death there is post-operative haemorrhage in the oesphagus; have you seen the death certificate in this matter?-- I saw it shortly.

You'll be aware that on the death certificate the primary cause of death is something called refractory shock?-- I can't recall, can I see the death certificate again?

Yes. Commissioners, I might tender that document that's before you.

COMMISSIONER: Well, that's part of the statements so I don't think we need to put it in separately.

MR ATKINSON: Of course. And then there is a cause of death certificate rather than the certificate itself. Perhaps we could put that on the screen again? Doctor, what is refractory shock?-- It's shock which doesn't respond to treatment.

And that's the kind of thing you might get from blood loss?-- Yeah.

But in a sense am I right, refractory shock is a symptom rather than a cause?-- Shock is a definite - has got a definite definition which is not basically - it has got definitely signs but - and can have multiple causes.

Right.

COMMISSIONER: Is it accurate to say that the late Mr Kemps died of refractory shock?-- Yes, that would be correct to say

that it was the cause of this, yes.

And why is that?-- Because he was continually bleeding, that we were giving him continuous blood products, basically he bled faster or more than he was given blood.

Well, that fits in with item 1B that the cause of death was the bleeding. Why would you say the cause of death was shock?-- It says "Due to aortic bleeding", so you get too little volume in the system, circulating system due to active bleeding and when you've got too little volume in your heart and blood vessel system, then the body doesn't get enough oxygen.

Yes?-- And that's why itself is shock, the definition of shock.

All right.

MR ATKINSON: Doctor, in the other chart that I showed you, there was reference to post-operative haemorrhaging. Would that not have made more sense of the cause of death rather than refractory shock that seems to be secondary?-- Refractory shock is basically a physiological term, I would say the cause is the bleeding, yeah.

Now, after the operation, when you took it to Dr Carter?-- That's right.

Can you tell us why you took it to Dr Carter? What was going on in your mind when you went there?-- The theatre staff which was involved in the operation were very unhappy about the whole conduct of the operation and then also that I knew that this patient has been not reported to the Coroner made me go to Dr Carter. I had a meeting first with the theatre staff who was involved with the operation and we went through all of their grievances.

So-----?-- -----and complaints.

So there were two issues, doctor, there were two issues: one was the concerns of the theatre staff?-- That's right.

And the other was that you considered that the matter might be or should be referred to the Coroner?-- That's correct.

Can we address them in turn?-- Yes.

With the theatre staff, is that just the nurses or other people as well?-- No, that was just the theatre staff who was involved.

Right, and that's the nursing staff?-- That's the nursing staff, yeah.

All right. And presumably you would only take their concerns to Dr Carter and if you could, your own concerns yourself that you thought they were well founded?-- That's correct.

D COMMISSIONER VIDER: Mr Atkinson, can I just make a comment? Dr Berens, you are the first person during all of the evidence we've received from clinical people, you're the first medical person that's ever gone back after an event to provide an opportunity for staff to discuss how traumatised the events have been and for that can I say thank you.

MR ATKINSON: So Dr Berens, you go to the nursing staff and discuss their concerns: which ones stood out to you that they were the ones you wanted to take to your line manager?-- That how the procedure was conducted, the way Dr Patel basically treated the theatre staff, but I personally listened to that and it was - a decision was made that they're going to make an official complaint and hand that then via their line of to who's responsible and that then go about that that way.

That they were to make their complaint through the nursing stream?-- Yeah, through the nursing stream.

But nevertheless, you took their complaints to Dr Carter?-- Yeah, I told Dr Carter about the findings or that the nursing staff was basically traumatised and that they didn't feel comfortable at all with the procedure how it had gone about.

And complaints like that, have you made them often during your career?-- No.

The other complaint, the other issue you took to Dr Carter was whether or not the matter should be referred to the Coroner?-- That's right.

And what resulted from your meeting with Dr Carter?-- We immediately - Dr Carter phoned Dr Keating and Dr Keating said that we can see him or was he immediately available to see him and then we went up and raised basically the issue of mainly of the patient not being referred to the Coroner.

Right. Can you tell us in the scheme of things was this the day of Mr Kemps' funeral or was it later or before?-- It must have been later.

All right. Now, when you spoke to Dr Keating, what concerns did you and Dr Carter give him?-- That first of all that this should have been reported and due to the Coroner's Act of 2003, and went basically through why we thought this had to be reported and that we didn't expect this patient to die, it was an unexpected death and yeah, that was the main reason.

Can I ask you this, doctor: Section 8 subsection 3 of the Coroner's Act refers to, "A death being reportable where it was not reasonably expected to be the outcome of a health procedure.", and you had - had you referred to the legislation prior to speaking to Dr Keating?-- That's right.

And was that a particular paragraph that you identified?-- Excuse me?

That paragraph that I just quoted?-- Yeah.

Was that the basis upon which you considered it should be reported?-- Yes, that's right.

So you explained why it should go to the Coroner and you also articulated the nurses' concerns?-- I can't recollect that we - that was a real issue at that stage because I assume this is going via the line of their - they take it through their own hands and they write their reports and so on.

Did you address with Dr Keating concerns about the way the operation was conducted as opposed to the outcome?-- No, we didn't spoke about how the operation, it was just said basically because according to this Coroner's Act, it says it was reasonable or was expected, it was an expected death that there was basically the argument how many of the previous same type of operations had gone well and it seemed that about every operation there was a complication or the patient died.

Can I go through that slowly. The question for the Coroner's Act you understood was whether death was a reasonably expected outcome of this procedure?-- Yeah.

And there was a discussion, was there, in the meeting to the effect that that death had actually been a fairly consistent outcome of oesophagectomies at Bundaberg?-- Yeah, consistent, that's true.

And for that reason perhaps, the death wasn't reportable; was that something that was discussed?-- No, no, no, no. I think if the others weren't - had the same outcome, then they should also have been reported.

All right. The converse of what I put to you?-- Yeah. But, I mean, the other reason - the other arrangement was basically that Dr Patel's not going to do these operations anymore at Bundaberg Hospital. Wasn't allowed.

That was something that came out of the discussion with Dr Keating?-- That's right.

And Dr Keating gave you an assurance that there would be no more oesophagectomies?-- That's correct.

By Dr Patel?-- That's correct.

How did Dr Keating respond to your concerns about your referral to the Coroner?-- Dr Keating wasn't very happy to hear about this whole incident and was arguing about was it really reportable or not, but it might be that he played devil's advocate at that stage; he was reasoning why would he report and want to report this patient, actually, to the Coroner.

Well, what became of that aspect of your approach?-- Well, the result was that Dr Keating said, yes, it would be fine or if we think this patient needs to be referred - or the Coroner needs to be informed, then we should go ahead and do that.

He didn't offer to take up that issue himself?-- No.

D COMMISSIONER EDWARDS: Could I just clarify, how soon after this man's passing did you meet with Dr Keating? Within days? You just say in your statement, "Shortly after his death"?-- Yeah, it was within days. I can't really recollect when, exactly how many days.

But it was within a few-----?-- But as it occurred, the patient had been buried already at that stage. So it must have been that period of time.

MR ATKINSON: Dr Berens, when you were talking to Dr Keating about previous oesophagectomies, how did you know or how did anyone at the meeting know the outcome of previous oesophagectomies? How did you have that information close to hand?-- I haven't, but Dr Carter and Dr Keating knew about that.

And do you know whether they discussed the number of previous oesophagectomies?-- It was three or four, somewhere there.

And all, as you say, with bad outcomes?-- Dr Carter was arguing for bad outcomes, all of them. Dr Keating said basically, "No, they haven't been all of them." But it seemed that they were definitely not in an acceptable outcome range.

Now, in paragraph 25 of your statement you make mention of Peter Leck and explain that you had little contact with Dr - with Mr Leck?-- That's right.

Did you generally have much contact with Dr Keating or Mr Leck in the course of your time from early January 2004?-- Not really.

Now, you mentioned that you were called to the executive offices in the course of 2004?-- That's right.

And you met there with Dr Keating and Mr Leck?-- Yes.

And there was just the three of you present at that meeting?-- Yes.

Now, at that meeting you were asked just generally to comment on Dr Patel ?-- That's right.

Were you told the trigger for that meeting?-- Yeah, there was a complaint made.

And do you know which - what complaint that was?-- Well, I knew that the ICU people would complain about this.

And were you asked to comment on a particular allegation or just to generally give your opinions on Dr Patel's proficiency?-- General opinion.

And can you tell the Commission what you told Mr Leck and Dr Keating?-- I told them basically that I thought that he's doing certain operations efficiently but I think that his knowledge is outdated and that he doesn't get along really with nursing staff well, and that he basically, when it comes - he starts to become erratic or when there seems to be a complication or bleeding or something like this, that he becomes more tense. But otherwise there was no specific complaints I made, or other things.

And you don't know at what stage in 2004 that meeting occurred?-- No, I can't recollect.

COMMISSIONER: Do you recollect whether it was before or after the operation involving Mr Kemps?-- No, it was actually before.

Before?-- Yes.

MR ATKINSON: Did Mr Leck or Dr Keating give any indication of

what they would do with the information they were gathering?-- No, they didn't give any.

COMMISSIONER: Doctor, I want to go back to the case involving Mr Kemps because there are some points I want to make perfectly clear. In your statement you attribute to Dr Patel the view that Mr Kemps had less than 12 months to live prior to the operation?-- That's right, that's what Dr Patel told - told me.

Yes. Did you yourself have a view about that?-- No.

But before you anaesthetised him, you assessed that he was at least fit and strong and well enough to have the anaesthetic?-- That's correct.

So he certainly wasn't at death's door at the time when he went into the operating theatre?-- Not at all.

No. Do you have any reason yourself to doubt that he could have survived for a further 12 months?-- It's very difficult to say. It depends very much about the tumour and how far it had actually spread.

Yes?-- So I haven't had, really, an opinion or thought about that.

No, that's quite all right. But he - as you say, he wasn't going to die within 24 or 48 hours?-- I would think not.

When Dr Patel left the operating theatre after performing the initial surgery, it was apparent to you that there was significant bleeding?-- That's correct.

And that the level of bleeding was such that would inevitably cause death unless attended to?-- That's right.

Is it your opinion that no surgeon who was acting with reasonable skill and care would have left the patient in that condition?-- Yes.

And that Mr Kemps' death was therefore a direct consequence of Dr Patel's decision to leave him with a bleeding vessel?-- That depends very much on where and what actually - where the bleeding comes from.

Yes?-- If another surgeon-----

But in this particular case, not as a hypothetical thing but in this particular case, knowing the level of bleeding and the fact that the patient was in effect sewn up without having the bleeding attended to, that was the direct cause of Mr Kemps' death?-- That's right.

In other words, from the moment Dr Patel left the operating theatre it was inevitable that Mr Kemps would not survive?-- If the bleeding is not attended to, yes.

Yes, thank you.

MR ATKINSON: Can I ask you a question, Dr Berens. You say in paragraph 15, as we discussed earlier, that Dr Patel maintained that he had less than a year to live, Mr Kemps. Did he say whether the operation was designed to buy him more time or whether that was a constant?-- I assume that's a palliative procedure. In other words, it is the quality of life of this patient would be increased with having that procedure and maybe the length of life also.

Commissioner, I tender Dr Berens' statement, and that's the evidence-in-chief.

COMMISSIONER: You don't propose to deal with the final paragraph? That's dealing with the 15-year-old boy whose name is to remain suppressed.

MR ATKINSON: Well, there's not much that I can say I don't think. Can I take you to paragraph 26 quickly. P26 is the boy, the 15-year-old boy, who had a through knee amputation in the event. You were involved in his treatment but not closely?-- Yeah, I was called in again by the anaesthetist who started off the anaesthetic.

There were three operations to that boy in the course of about 12 to 13 hours but you weren't involved in any of the operations themselves?-- I was always called, basically, for the - to assist the anaesthetist who was starting off the anaesthetic.

Right. All right. And you noted post-operatively that the boy was in a good deal of pain?-- That's correct.

That's the evidence-in-chief.

COMMISSIONER: Thank you. The statement of Dr Berens will be Exhibit 128.

ADMITTED AND MARKED "EXHIBIT 128"

COMMISSIONER: We have lost some time this morning so we will have a very short break, five minutes, and then resume.

THE COMMISSION ADJOURNED AT 12.10 P.M.

THE COMMISSION RESUMED AT 12.24 P.M.

COMMISSIONER: Mr Atkinson.

MR ATKINSON: Commissioner, there is just one final thing that doesn't actually relate to Dr Berens' evidence but it seems like an opportune time. There was reference in The Courier-Mail today to a review of the Rockhampton Base Hospital Emergency Department and a report commissioned and obtained by Queensland Health dated June 2004. Commissioners, I have obtained a copy of the report. It is relevant particularly to this extent, that at page 14, which I have flagged, there is discussion about a recurrent theme of overseas trained doctors and their competencies. Can I tender that if I may?

COMMISSIONER: Yes. May I see the report?

MR ATKINSON: I hadn't identified the front page, Commissioner.

COMMISSIONER: No. We can deal with that in due course.

DIETER BERENS, CONTINUING:

COMMISSIONER: Yes. The Queensland Health report into the Emergency Department at Rockhampton Hospital dated June 2004 prepared by Dr Peter Miller and others will be Exhibit 129.

ADMITTED AND MARKED "EXHIBIT 129"

COMMISSIONER: Mr Boddice, are there any more of these secret reports going to come out of the woodwork? We'd really prefer to hear about them from Queensland Health rather than - I know Mr Thomas does a great job but it's not his job to be providing evidence to the inquiry.

MR BODDICE: Well, Commissioner, all we can say is that when we saw that this morning, we arranged - we made inquiries to ensure that a copy could be provided. I could make inquiries to see whether there are any similar.

COMMISSIONER: Going back to the initial submission, and I know that Queensland Health isn't bound by it, but we were given all sorts of assurances about how procedures and practices and systems were in place and ever since then we've received this sort of drip fed - perhaps I shouldn't use medical analogies. Drip feeding that shows there is also these time bombs locked away in cupboards.

MR BODDICE: A lot of documents have been provided and all I can say is that, certainly from my instructions, we are doing

the very best we can to provide all of the relevant material, and I can make inquiries as I said, Commissioner. But certainly, when I became aware of that this morning, I put in train steps so that a copy could be provided.

COMMISSIONER: Perhaps, Mr Boddice, it is worth suggesting to the Director-General or whoever is the responsible person to consider giving us reports that he wants us to see. Perhaps giving us the ones that he doesn't want us to see would be a good start.

This is just so squarely on point. I mean, you have got a high level investigation. It talks about, "The orientation of overseas trained doctors is a statewide issue. There no longer appears to be coordinated statewide approach to this issue. Given the chronic recruitment problems faced by the Rockhampton Hospital it may be beneficial to quality clinical care and staff retention if the district were to explore the origin of developing a locally based contract", and so on and so forth. It seems to be exactly the things we're talking about here, and I haven't been through it all but it seems to be fairly damning about the level of clinical competence at Rockhampton.

MR BODDICE: All we can do is I will give you my assurance that I will convey what you have said and that we will ensure that if there are other relevant reports that haven't been provided, that they will provided.

COMMISSIONER: Mr Boddice, as a matter of course, none of this is aimed at you and I have complete confidence in whatever you endeavour. Thank you, Mr Thomas, for bringing the truth to light yet again. Mr Boddice, do you have questions for Dr Berens?

MR BODDICE: We do.

COMMISSIONER: Thank you.

EXAMINATION-IN-CHIEF:

MR BODDICE: Dr Berens, could we commence with the death certificate. You were asked some questions about refactory shock. Refactory shock is a medical condition, isn't it?-- Yeah.

It's a condition where insufficient blood is delivered to the tissue so the body, in effect, goes into shock?-- That's right.

So the death certificate is indicating that that was the cause of death; that is, this shock where there's insufficient blood?-- That's right.

And then sets out what was the cause of the bleed, in effect, that resulted in that shock?-- That's right.

Doctor, you also were asked some questions about the surgeon's report. I'm not actually sure what documents you were given but could I just give you the record so that you could just identify for the Commissioner. You will see I have the record open at a page for a surgeon's report?-- Yes.

And that would appear to be the first operation?-- That's right.

And was that the one you were looking at before?-- That's correct.

Then there is, you will see on the page in front of it, a report for the second operation?-- Yes.

Does that report refer to the fact that there's a bleed and that is why the second procedure has occurred?-- There are - this is the second - basically, the second operation and the second report.

Yes. Does it refer to the fact that the second procedure was because there was a bleed?-- In the above statement it says, "Diagnosis & Operation: performed post-oesophagectomy post-op bleeding".

Yes?-- So it actually says that.

Yes. You see there is another yellow tab just another couple of pages in front that is to your left. Is that also a surgical note?-- Yes, that's right.

And does that appear to be a note which has occurred after the first operation?-- Yes.

And before the second operation?-- That's right.

And it sets out that there is this bleed?-- Yeah.

And the steps being taken in relation to the bleed?-- That's right.

So when you were shown the records before, you only had one - the first operation record; is that the case?-- That's correct.

Commissioner, I'll tender those as a bundle. I'll have to have them extracted, of course, from the records to have a copy taken.

COMMISSIONER: Yes. At lunchtime one of your team might liaise with the secretary to have those photocopies, and photocopies of the surgical notes regarding Mr Kemps will become Exhibit 130.

ADMITTED AND MARKED "EXHIBIT 130"

MR BODDICE: Thank you. You also in your statement - you were taken to paragraph 8 of your statement when you spoke about the concerns in relation to the giving of blood to a patient?-- That's right.

Could you just explain that a bit further. What was the concern?-- That patient had - was still in a range of a haemoglobin, which was or is thought to be acceptable for this patient, and he received blood. And to give blood has certain complications that - it can suppress immunity and you can get reactions and so on and it is not indicated to give that in that range.

So when you speak about Dr Patel said, "He did not need to give me any evidence", was the dispute between Dr Patel and yourself, was that because of the haemoglobin readings? You didn't consider it was necessary to give blood at that time?-- Yes.

But Dr Patel's view was that it was necessary to give blood at that time?-- He didn't discuss it with me at all.

Well, he said - all right. I take your point. Dr Patel said, "He did not need to give me any evidence"?-- That's right.

But was that in the context of your expressing the view that the levels were such that you didn't consider it was necessary to give blood at that time?-- That's right.

So the dispute was about the giving of the blood?-- That's right.

Yes, thank you.

COMMISSIONER: Thank you, Mr Boddice. Who would like to go next? Mr Mullins?

CROSS-EXAMINATION:

MR MULLINS: Dr Berens, can I establish the chronology of events and the relevant time frames from the first and second surgery? From the documents that you have before you, can you inform the Commission of the time of the first surgery? Is it recorded on the surgical note, for example?-- Yeah, it is recorded or I recorded it myself. Basically, it was - the surgery, itself, from 10 o'clock till half past 1.

COMMISSIONER: I should have explained, Dr Berens, the gentleman asking you questions is Mr Mullins, and he represents the patients of Dr Patel?-- That's right.

MR MULLINS: I apologise, Commissioner.

COMMISSIONER: Not at all.

MR MULLINS: The nursing records, themselves, indicate that Mr Kemps was transferred from the operating theatre at about 1.30 p.m. to the ICU?-- Yep.

And then it appears Mr Kemps was transferred at about 9.45 back to the operating theatre?-- Yep.

So the time frame or the delay, at least, was about six hours or six hours and 15 minutes-----?-- Yep.

-----between the time when he was taken from the operating theatre back to ICU and the time that he was returned back to theatre?-- Yeah.

Another witness, Toni Hoffman, expressed her concern that she wasn't aware why the ICU was left trying to stop the bleeding or maintain stability and why it was that doctor - sorry, that Mr Kemps wasn't simply returned to the operating theatre. We now know, and you confirm, that it's the case that it was simply that Dr Patel was engaged in other surgery?-- That's right.

That was the sole reason for Mr Kemps not being returned to theatre for the further surgery to stop the bleeding?-- Yep.

Now, you also mentioned in your evidence that you considered this to be a matter that should have been reported to the coroner?-- That's right.

And you were of that view right from the outset?-- Yes.

Can I ask you to look at the nursing note? You have it annexed to your affidavit. It's the document about six pages in, and it includes the note of Dr Patel at 6.50 p.m. on 21st December 2004. It's annexed to your affidavit. That might be the easiest place to find it. It was actually the document that was on the - on the overhead with the green highlighting. It's a nursing note of 21 December 2004. I can give the

witness a copy, Commissioner?-- Is that-----

COMMISSIONER: Doctor, do you have your statement there? It should be attached to the back of your statement?-- All right.

MR BODDICE: Commissioner, it's the fifth page in of the annexures?-- Yeah.

MR MULLINS: Can you put the document on the overhead? Just to refresh your memory on the document, it's the one we looked at earlier. The first half of the document is the note of Dr Patel?-- Yep.

I'm interested in the second half of the document, and we can see that that's a note of, if we go to the bottom right-hand corner, that's Dr Cresswell?-- Yep.

Do you know Dr Cresswell?-- No.

Is the initials "JMO" Junior Medical Officer - sorry, Junior House Officer?-- Yeah.

And that's "ICU" next to it?-- Yeah.

Now, if we read that note we see that Dr Cresswell says that on the 21st of December 2004 at 9.50 a.m., "asked to confirm death. Patient remains ventilated. No cardiac output on heart monitor. Unresponsive. Pupil's fixed and dilated." Next line, can you interpret that?-- No vital signs for more than one minute.

Next line, "death confirmed at 920 hours" and "ventilator"?-- Switched off.

"Switched off. Family present. Time of death 915 hours." Cause of death is described. I'm interested in the next sentence, "Dr Patel's team informed and will write death certificate and inform coroner", and "Rest in peace Gerard Kemps"?-- Yeah.

Can you recollect whether you were working at 9.15 a.m. on 21st December 2004?-- Yeah, I was working.

Can you recollect whether any person informed you on 21st December 2004 that this was a matter that would have been reported to the coroner?-- No.

Were you present for any discussion in respect of whether there would be or might be a referal to the coroner at that time?-- No.

Did any other person, prior to your discussions with Dr Carter, suggest to you that this would be a matter that would be referred to the coroner?-- That was with the nursing staff. We were quite agreeable with it, that it should be referred to the coroner, yes.

Again, just wishing to establish the chronology, that's the 21st of December 2004. Now, Mrs Kemps has informed the Commission that the funeral occurred on the 23rd of December 2004, and you believed that your discussion with Drs Keating and Carter-----?-- Yep.

-----was after the funeral?-- Yes.

Now, you mention that you had a discussion with the theatre staff?-- That's right.

Are you able to say whether your discussion with the theatre staff was before or after Mr Kemp was buried?-- Must happen after.

All right. In your discussion with the theatre staff were you advised at that time that there was not to be a report to the coroner?-- Let me ask the question another way. During the discussion with the theatre staff was it generally believed or discussed that this matter would be referred to the coroner?-- Yeah, that was the general feeling, yes.

Can you help the Commission with who was present at this discussion with the theatre staff?-- Oh, I know them all by first names.

First names will be a good start?-- It was Damien, Murray, David, Katrina, and Janelle were-----

Can you just run through those for me again, Damien?-- Murray.

Murray?-- Yeah, Katrina, David and Janelle.

And you believed at that time or at least the discussion or the group was of the view that the matter would be referred to the coroner?-- I can't recollect that we actually touched the issue of referral - reference to the coroner. No, I think-----

So you say-----?-- Yeah, no, I think I actually went when it was decided to see or to come together and speak about the whole operation. I actually went then to the intensive care unit and had a look, was this patient actually referred to the coroner or not, and then I realised it wasn't actually referred, according to the documentation - that it wasn't referred to the coroner and that then everybody was aware of that fact that this patient wasn't referred to the coroner.

Now, are you able to say or certainly you were not consulted about whether the patient should be referred to the coroner-----?-- No.

-----at that point?-- No.

Did any of the theatre staff say that they had been consulted about whether the patient should be referred to the coroner?-- No.

Following your discussions with the theatre staff you've described that you attended with Dr Carter at a meeting with Dr Keating?-- That's right.

And we've established now that that was, at least, after 23 December 2004?-- Must have been after the burial, yeah.

Did you think that the - the fact of the burial had a significant impact on any prospect of coronial request for a valuable coronial inquest?-- That we didn't go ahead, basically, in ourselves and inform the coroner, yes.

Why didn't you go ahead and inform the coroner, yourself?-- Because we thought that under those circumstances the family went through the grievance already, the patient has been buried and that would be too much of a trauma, basically, to them, to suddenly realise there is - this patient should have been actually gone to the coroner and has to be exhuminated now, yeah.

Did you know at the time of any formal complaints process or adverse reporting process that you could proceed through to formally record any complaint that you had about Dr Patel's conduct?-- Well, yes.

And did you file a formal written complaint or complete any adverse event or incident form?-- No, not official, not documented, no.

Now, you had already made a complaint or expressed your concerns to Dr Keating?-- That's right.

Why is it that you didn't proceed to complete an adverse event form or complaint?-- Because I thought that a verbal complaint to the Director of Anaesthetics and the Director of Medical Board Services should suffice, and if they want to write me - write to have it documented I would do so.

Your previous complaint about Dr Patel or, at least, your discussion with Dr Keating about Dr Patel was in February of 2004?-- That's correct.

Had you had any further discussions with Dr Keating in the intervening period about the conduct of Dr Patel?-- No, not that I can recollect, besides the time where I was called in after the ICU personnel complained and to give evidence about what is my feeling about Dr Patel, yes.

Did you have any history of making complaints other than the complaints about Dr Patel?-- No.

Did you have any perception, yourself, about how complaints against Dr Patel were being handled by Dr Keating?-- No.

You've mentioned in your evidence that you became aware during the course of 2004 that Dr Miach was refusing to allow his patients to be treated by Dr Patel?-- Yeah, I became aware

about that, yes.

After you discovered that, did you attempt in any way to get to the bottom of why it was that Dr Miach was refusing to let Dr Patel treat any of his patients?-- Well, it was well-known that the patients had such bad outcomes, that he didn't want to have them treated by Dr Patel.

Did you consider that that was limited to the surgery that might be related to the Renal Unit rather than surgery in general?-- Yes, because it's vascular type of surgery which needs more specific expertise than general surgery.

Does that show, to your understanding, that example of the lack of insight of Dr Patel and to his own limitations in surgery?-- Yes.

Thank you, Commissioner. I have nothing further.

D COMMISSIONER VIDER: Were you a member of any audit, clinical audit type committees by how whatsoever named in the hospital, such as the Mortality and Morbidity Committee or a review of the surgical services whereby cases that had had complications were reviewed?-- No.

Did such committees meet, to your knowledge?-- No idea.

Thank you.

MR MULLINS: I'm sorry-----

COMMISSIONER: Yes.

MR MULLINS: -----before I sit down: Dr Berens, did you at any time between January 2004 and early 2005 speak to Dr Gerry Fitzgerald about the conduct of Dr Patel?-- No.

Thank you.

COMMISSIONER: Mr Devlin?

MR DEVLIN: Just a few questions, Commissioner.

COMMISSIONER: Thank you.

CROSS-EXAMINATION:

MR DEVLIN: I represent the Medical Board of Queensland. My name is Ralph Devlin, Dr Berens. Just a few questions. Go back to paragraph 4 of your statement, three and four. You qualify in anaesthetics in South Australia arriving - South Africa, arriving in Australia in 1999?-- Yes.

Was there a professional reason why you did not seek

specialist qualification here until May of 2002? I'm just interested to know if there was any practical barrier that you encountered to immediately applying for your specialist qualification or setting about achieving it?-- There's a certain way you have to go about to actually become a specialist. You have to, first of all, apply at college for it and then they give you certain - minimum requirements, and my requirement was to write a OTS exam and to work for a year in acknowledged institution, and Mount Isa is not an acknowledged institution. I had contract there for a year, so - and, Bundaberg, there was no other position available.

In Bundaberg was there a position sufficient to satisfy the college?-- No, there wasn't here at that stage.

So how did you overcome that barrier?-- Going to Ipswich.

I see. Do you see that as a - do you see that as a practical barrier to people in your position that positions of areas of need, for example, that are available don't allow people with overseas specialist qualifications to immediately set about satisfying the college?-- That's right.

You see that as a practical-----?-- Yeah.

-----a practical barrier to those persons achieving their specialist qualification in a quicker time?-- That's right.

Thank you. Were you ever in a position to see if clinical notes that were entered by Dr Patel were in any given instance inaccurate and not reflective of what occurred in the operating theatre?-- I generally didn't read his notes.

That's not really part of your general duties?-- No.

My next couple of questions are not in any sense a criticism of you. I'm just interested in your state of mind at the time that these events with Mr Kemps unfolded. Did it ever cross your mind that there was a method of complaint to the Medical Board of Queensland or, alternatively, that it might be suggested to the relatives that a complaint to the Health Rights Commission was open to them; did either of those options ever cross your mind?-- No.

Were you aware of those sorts of options at the time?-- No.

And would your mind set have been that your first response was to try to raise the concerns internally?-- Yes.

And to give further information if you were called upon to give it?-- That's right.

And in this instance it sounds like you would have been happy to give it if you had been asked for a formal written description of what you say took place?-- That's right.

Thank you. You say that one of the outcomes of the meeting with Dr Keating and Dr Carter was that Mr - Dr Patel was not

to do any more oesophagectomies?-- That's right.

Do you have any information - did any information come to your attention that any further oesophagectomies were done or attempted by Dr Patel after that time?-- No.

Thank you. That's all I have.

COMMISSIONER: Thank you. Mr Allen?

MR ALLEN: Thank you, Commissioner.

CROSS-EXAMINATION:

MR ALLEN: Dr Berens, I'm appearing for the Queensland Nurses Union. You mentioned in your statement and your evidence a confrontation with Dr Patel about a clinical matter involving giving a patient blood?-- That's right.

And that, eventually, led to you meeting with Dr Keating?-- That's right.

I simply want to try and ascertain whether an incident described by - and statement of a nurse, Jan Maree McClure, relates to the same occasion or, perhaps, another similar occasion. Now, Ms McClure has stated that she became aware that you had been involved in a confrontation with Dr Patel regarding a clinical matter, and as a consequence had left the intensive care unit. Her understanding was that Dr Patel had been crossing out your orders for the patients and substituting orders of his own. Were they any of the circumstances which, perhaps, related to this occasion that you've described?-- I can't recollect any of that, no.

Do you recall that ever occurring, that Dr Patel would countermand orders you made in relation to patients in ICU?-- Can't recollect that, no.

It seems that Ms McClure received information that there had been a verbal altercation which ended with you walking out of the unit and telling Dr Patel that he could look after all of the patients?-- That's right.

And this caused great concern to the ICU nurses because they held you in much higher regard than Dr Patel and, indeed, I suggest that Ms McClure spoke to you, explained that the nurses were concerned that Dr Patel was not qualified to look after the patients and that they wanted you to return?-- That's right.

Was that this same occasion involving the disagreement with Dr Patel in relation to the giving of blood to patient P40 or was it another occasion?-- It's the same occasion.

The same one, okay. And you indicated, of course, that you would come back and resume care of your patients, but you indicated that you had become upset about the continual interference by Dr Patel in relation to the patients?-- That's right.

And, indeed, Ms McClure, I suggest, told you that she would be contacting Dr Keating to inform him of the situation?-- I can't recollect that.

Okay. Could it be that - do you recall whether you went and contacted Dr Keating about this matter or did he get in touch with you after, apparently, receiving information from another source?-- I was contacted by Dr Keating.

Okay. Now, in relation to Mr Kemps, I suggest that on the morning of the 20th of December 2004 an anaesthetic nurse Damien Gaddes telephoned you about the situation which had arisen, in that Mr Kemps was scheduled for surgery, but that there were already two ventilated patients in ICU?-- Yep.

And Mr Gaddes raised with you the possibility of postponing or cancelling Mr Kemps' surgery?-- That's right.

And you agreed that the case should be postponed?-- Yep.

And Mr Gaddes said that he would telephone or notify Dr Patel?-- I can't recollect any of that, no.

Well, in any event, you are aware that Dr Patel didn't agree to the postponement of the surgery?-- Which date are we talking about now?

The 20th of December 2004?-- Oh, yeah, no, he didn't - he was quite adamant that he proceed.

Quite adamant?-- Yes.

Are you aware as to the circumstances under which a ventilator did become available in ICU that day?-- Yes.

And that involved a patient's ventilator being turned off?-- I heard that, yes.

You weren't actually present?-- No.

Or physically involved?-- No.

Okay. Now, during the first operation, I suggest that at half an hour into the surgery there was already obvious excessive bleeding of the patient?-- There was bleeding, but I don't know if you can state that excess is obvious.

All right. Well, the haemoglobin had dropped from 75 grams to 70 grams per litre? Would that indicate a problem?-- But that's not an indication, that's - when you give fluid as a relative measurement - if I give a lot of fluids without having any blood in it, even if the patient doesn't lose any blood it will drop down.

The patient's heart rate was climbing steadily during the surgery?-- That's right.

And I suggest that at around that stage Mr Gaddes said to Dr Patel words to this effect: "Dr Patel, the bellovac drain is over half full with no vacuum and is still draining freely." Do you recall Mr Gaddes voicing some concern as to the bellovac drain during the surgery?-- The bellovac drain is usually put in after closure, or with the drain when the surgery of one cavity is finished, then they put the drains in and then they close and only after that it can fill up.

Okay. I am suggesting this is during the thoracotomy?-- It must be during the thoracotomy, yes.

Following the laparotomy?-- Following the laparotomy, yep.

Can you recall Mr Gaddes voicing concern as to the bellovac

drain?-- I can't specifically recall - recollect that, no.

I suggest that during the surgery you relayed information to Dr Patel in relation to the arterial blood gas and haemoglobin?-- I can't specifically recollect that I actually told him - I told him basically I think this patient is bleeding, and it is logic type of - but I can't specifically recollect that.

I suggest you in fact conveyed your impression to Dr Patel the patient was haemorrhaging?-- Yeah.

Now, after the operation concluded and Dr Patel had left the theatre, did you in fact request, because of your concern as for the patient's condition at that time, for someone to go and get Dr Patel to review the patient as you were concerned about the blood loss?-- Yes.

And a Dr Kariyawasam returned?-- Yeah.

You are familiar with that doctor?-- Sanji I know him as, personally.

What's his position at the hospital?-- He was surgical PHO, as he was working together with Dr Patel and assisting him.

So he in fact had gone and attempted to persuade Dr Patel to come back to the theatre at a stage where Mr Kemps was still in theatre following the first operation?-- I assume so.

And he advised the staff there, including yourself, that Dr Patel's orders were to admit the patient to the ICU?-- Yeah, basically we did that, yep.

And that was met with some degree of disbelief on your part?-- Yes.

And you in fact said words to the effect of, "This patient will be back to theatre tonight."?-- Yes.

Because it was obvious to you there, and should have been obvious to Dr Patel that there was a very serious situation existing with that patient at that time?-- Yes.

Now, if I could please see the surgical notes or report that you have been asked to look at? I believe they are still in the records in front of you?-- Yep.

COMMISSIONER: If the attendant would bring that across, it is a manila folder, isn't it? Do you want the single page or the entire folder?

MR ALLEN: The single pages would be convenient, please, Commissioner.

COMMISSIONER: I think there is one single page.

MR ALLEN: There was reference made to a second surgeon's

report.

COMMISSIONER: Yes, that's in the manila folder.

MR ALLEN: If I could have the manila folder then, please.

COMMISSIONER: I think if you go to the yellow sticker it will assist.

MR ALLEN: Yes, if I could ask to have that part of the second report on the visualiser? Perhaps if we go out a fraction? Okay, thank you. Now, these are notes made by Dr Patel, as you understand it?-- Yes.

And I only want to look at part of what's on the screen there, but under "Indications for Surgery" it seems to read "Patient underwent oesophagogastrectomy by Ivor-Lewis approach in the morning". Do we see there "(uneventful)"?-- Yes.

Now, that's a complete falsification, isn't it?-- That's true.

Okay. "Noticed to have increased" - I can't read that. Can you?-- No, I can't. "Drainage" I can, but the first word-----

Okay, "from abdo drain received transfusion." Now, if we look there "four hours" - is that "post"-----?-- "Post-op patient became hypotensive with abdominal distension with drainage from test tube."

From your observations would it be correct observation it was only four hours post-op that the patient became hypertensive?-- No, that's not true.

The patient was showing symptoms of hypotension from the time of the first operation?-- Yes, we had to give him a lot of blood, basically, to keep the blood pressure up.

And then throughout the period of hours after the patient left the theatre, he was in ICU?-- Yes.

So that's also a complete falsification, isn't it?-- That's true.

Yes. Thank you.

D COMMISSIONER VIDER: Just before we move off that, splenectomy is written at the top of that page beside thoracotomy?-- Yes.

Did Mr Kemps have a splenectomy as well?-- Seemed to be part of the complication when he started to bleed, a reason they actually injured the spleen during that period of time.

COMMISSIONER: I think it has been suggested in someone else's evidence, hasn't it, Mr Allen, that when the bleeding was noted, Dr Patel thought it might have been coming from the

spleen, so he took the spleen out as a precaution.

D COMMISSIONER VIDER: Mrs Kemps said that.

MR ALLEN: During the second operation, yes.

COMMISSIONER: Yes.

MR ALLEN: Yes, thank you, that's all I need for that.

COMMISSIONER: Doctor, I am not sure if this is appropriate within your expertise, but I have been told from other evidence that you can fairly easily tell whether a spleen has been damaged or not because it is almost as if it is under pressure. I have been given the example of a balloon full of water, you can feel it is under pressure, and if there is blood coming out of the spleen, you can tell very easily. Is that-----?-- Well, I wouldn't give any comment about that. It is not my expertise.

MR ALLEN: Doctor, just one other matter, you refer in paragraph 7 of your statement to the patient that was treated in about February 2004 by Dr Patel underwent an anastomosis?-- That's right.

And then underwent a reanastomosis?-- Yep.

Because of leakage?-- Well, yeah, I would assume so.

Yes. Now, could I ask you to look at Exhibit 5, if the Commission pleases, which is the key of patient names?

COMMISSIONER: What's the purpose of this?

MR ALLEN: I want the witness to see if he can recognise the name of patient P40 as being the patient he refers to.

COMMISSIONER: Take my copy. It is largely unmarked.

MR ALLEN: If you could look there to a reference to P40?-- Yeah, that is the patient.

That is the patient?-- Yep.

Yes, thank you. Now, in relation to P40 then, Deputy Commissioner Vider asked you whether in fact the reanastomosis had been recorded as such and you were unable to assist. You recall that question being asked?-- No.

Okay. Well, it was - you might be able to assist us here. If patient P40's records include a letter dated the 15th of March 2004 regarding the patient from the surgical intern for Dr Patel to another - to a general practitioner, and it does note that on the 23rd of February 2004 the patient was "admitted for reanastomosis of a double colostomy." So if the intern is informing the general practitioner of that, would that seem to suggest that Dr Patel would have recorded the procedure as being a reanastomosis?-- The procedure which was

done was a reanastomosis and that seemed to read reanastomosis, so the operation was later on.

Now, just in relation to that patient, the patient ended up staying in ICU for some weeks after that procedure. Is that correct?-- I have to refer to my memory. I didn't go through this patient's charts.

I just finally want to ask you whether you have a recollection of some matters regarding that patient which are dealt with in a statement from a registered nurse in the ICU, Kay Boisen. The reanastomosis, as I said, occurred on the 23rd of February 2004. Can I suggest that on the 4th of March 2004, that patient was in ICU because of abdominal sepsis which had failed to improve despite antibiotic treatment, and that on that day you spoke to Dr Patel regarding your concerns about that patient?-- That's right.

That that discussion focussed on the patient's lack of improvement, ongoing problems and current deteriorating ventilatory status?-- That's right.

And that you expressed the strong view that the patient should be transferred to Brisbane?-- I can't recollect that.

I suggest that on that same date at 10 a.m. you made notes in the medical chart noting "review" and those notes included "query transfer to RBH"?-- That could be quite possible.

And I suggest that at that time the ICU was at capacity with two ventilated patients and that you were of the opinion that the patient should be transferred to Brisbane as he was the youngest and sickest and more in need of tertiary level care?-- Yes, that sounds quite right.

Would this be consistent with your dealings with Dr Patel on issues such as this, that he was very forceful in saying that the patient would not be sent to Brisbane?-- Yes.

And that he said that he would approach the executive to increase staffing of the ICU to accommodate his post-operative patients?-- Yes.

Said that the executive would do that as he was generating money for the hospital?-- I don't know why the executive made that decision.

No, this is what Dr Patel said, I suggest?-- I can't recollect that he actually gave a reason.

And that-----?-- That he was going to make money, things like that. I can't recollect that.

Do you recall him ever saying that if the ICU could not accommodate his post-operative ventilated patients, the hospital would lose a lot of money?-- No, I can't recollect the financial implication, no.

Okay, all right. Well, I suggest-----

COMMISSIONER: Do you recall Dr Patel ever saying anything along those lines, commenting on how much money he made for the hospital or how much the hospital would lose if patients were sent away?-- Yeah, no, he definitely was quite clear in the picture how much money per patient the hospital was getting per operation type of thing, yes. He was making those comments. He knew how much a laparotomy, collectomy, how much money that was going to be, et cetera. Yes, he was aware of that.

MR ALLEN: Did he ever suggest that he, because of those matters, enjoyed the support of the executive?-- I suppose that it sounds the way - it seems to, yeah.

COMMISSIONER: Doctor, it is not being suggested that's true. It is not being suggested that the executive actually did have some special favours for Dr Patel because he made a lot of money, but the suggestion is that Dr Patel claimed that he had a special influence with the executive. Do you recall him making that sort of claim?-- No, that he has got special influence, no.

MR ALLEN: Thank you, Commissioner. Thank you, doctor. Does anyone want lunch?

MR DIEHM: I am sorry, Commissioner.

COMMISSIONER: Do you want lunch?

MR DIEHM: I am in your hands. I will be 10 or 15 minutes, I think.

COMMISSIONER: Well, I had actually hoped to finish this doctor before lunch, but will there be anyone else with any questions?

MS FEENEY: No, Commissioner.

MS GALLAGHER: No, Commissioner.

COMMISSIONER: All right, away you go then.

MR DIEHM: Thank you.

CROSS-EXAMINATION:

MR DIEHM: Dr Berens, just one of the formal parts of your statement, you talk about your history in terms of coming to Australia and your obtaining Australian qualifications. Are you an Australian citizen?-- Permanent resident.

A permanent resident. When did you acquire that status?-- In

2000 and - when I was in Hervey Bay. 2002 - 2002, end of 2002, December.

COMMISSIONER: Dr Berens, please forgive me. I forgot to mention that the gentleman asking you questions is Mr Diehm, and he represents Dr Keating in these proceedings.

MR DIEHM: Forgive me, too, doctor, I neglected to mention. Doctor, if I may move on then to the matters concerning your raising with Dr Keating the issue of the confrontation that you had had with Dr Patel concerning the giving of blood to a patient?-- Yep.

Now, I gathered from your evidence and answers to questions from Mr Atkinson that the way you recalled the meeting unfolding with Dr Keating was that you, early on in the meeting, explained to him what your concerns were, what the issue was about?-- Yes.

So you did go into discussion with Dr Keating about the clinical matters that were of concern to you?-- No, I just told him what was the issue about.

Did you tell him that it was about a dispute over whether or not this patient should have been given blood?-- Yes, about haemoglobin, yeah.

Okay. So you say in paragraph 9 of your statement, if you have got it there in front of you, the final sentence reads: "I was not asked to discuss the reasons for the dispute between Dr Patel and I."?-- That is not exactly the right wording, basically, for that. I was - I was given the opportunity to - or I told Dr Keating, basically, from the beginning that what was it about, but the sentence is such as I wasn't asked to go into detail about the issue.

You weren't asked to go into the scientific background-----?-- No.

-----if you like, of your position?-- No, that's right.

Following your explanation about the issue to Dr Keating, was there discussion about the fact that what was being spoken about was a difference in clinical opinion between you and Dr Patel?-- That's right.

And did Dr Keating suggest to you that as professionals and as grown men, that was something that you ought be able to talk about and sort out between yourselves?-- That's right.

Now, were you satisfied with that approach by Dr Keating to the problem?-- I was quite happy with that.

All right. And you did leave the meeting and eventually have a discussion with Dr Patel about these matters?-- Yes.

So would it be fair to say that following that process you were content with the way in which this matter was dealt with

by Dr Keating?-- That's right.

Now, the next matter I wanted to ask you about concerned the meeting that you had with Dr Carter and Dr Keating concerning P21-----?-- Yes.

-----the patient who had the oesophagectomy in December of last year. You mentioned in your evidence earlier that during the meeting there was some discussion about Dr Patel's history with patients having oesophagectomies-----?-- That's right.

-----at the Bundaberg Hospital. If I were to suggest to you that the history prior to the operation upon P21 was that there had been three oesophagectomies performed by Dr Patel since he arrived at the Bundaberg Hospital and that two out of those three patients survived their procedures, does that accord with your understanding about what Dr Patel's history was prior to P21?-- I have no idea what was his history prior to P21.

Okay. Does what I have just outlined to you accord with your recollection about what was discussed about Dr Patel's history with oesophagectomies in that meeting?-- Excuse me, can you-----

Yes. What I have just outlined to you as a history, what I have suggested to you is what the history of Dr Patel was with oesophagectomies, was that the history that was discussed in your meeting with Dr Keating and Dr Carter?-- Yes, that was the history.

So prior to P21, three oesophagectomies, two of them successful?-- I don't know. There was at that stage when the discussion was going on, nobody really had definite data.

All right. Now, you related that Dr Keating you thought might have been playing the devil's advocate with respect to questioning about why it might be that this case was one to be referred to the Coroner?-- That's right.

So by that do you mean that Dr Keating was asking questions of each of you and Dr Carter as to why it was that you thought-----?-- That's right.

-----this patient should be referred to the Coroner. And in the course of doing that, you were free to tell him your reasons as to why you thought that was so?-- That's right.

Was there also discussion about what disadvantages there might be in referring the patient to the Coroner?-- Yeah, there was.

And was that disadvantage that was identified that the - there would, in effect, have to be an exhumation of the body?-- If the patient was buried, yes.

That was the only negative thing that was discussed as to notifying the Coroner?-- That's right.

And did Dr Keating leave it with you on the basis that if you thought - and when I say you, if you and Dr Carter thought that the matter was one that was appropriate to be referred to the Coroner, then you should feel free to do so?-- That's right.

However, was it the state of mind of yourself, and, in your understanding, Dr Carter as well, that you were not inclined to refer the matter to the Coroner because of the potential adverse impact upon the family?-- That's right.

Now, Dr Keating also asked you, did he not, about whether you took the view that there should be no more oesophagectomies performed by Dr Patel?-- Yes.

And your answer to that - when I say you again, you or Dr Carter, or both of you - your answer to that was that that was your view, there should not be any more oesophagectomies?-- That's right.

And Dr Keating gave you an assurance that there would be no more?-- That's right.

Thank you. Thank you, Commissioner, that's all I have.

COMMISSIONER: Mr Boddice, any re-examination?

MR BODDICE: No, thank you, Commissioner.

COMMISSIONER: Mr Atkinson?

MR ATKINSON: Couple of quick questions, Commissioner.

RE-EXAMINATION:

MR ATKINSON: Dr Berens, two issues. First of all, you were asked questions by Mr Allen over there about the fact that there were the two ventilators in ICU were already being used prior to the Kemps' operation and that Dr Patel was upset about that and then suddenly a bed became free?-- That's right.

Are you aware of the guidelines that doctors use in deciding whether or not a ventilator can be turned off?-- Yeah.

And who issues those guidelines?-- I can't tell you the exact body. There is a general worldwide acceptable guideline which exists. I don't know who the body - who actually established the guideline.

But you used the very same guidelines in South Africa?-- That's right. It is worldwide.

What are the guidelines, in short?-- Basically you see if the patient is brain dead and you do certain tests for that.

They are brain stem tests?-- They are brain stem tests.

They are done by two independent doctors?-- That's right.

And one other issue, you recall you were asked questions by Mr Boddice over here about the surgeons' reports?-- Yep.

And you might recall in evidence-in-chief I showed you two surgeons' reports. The second one was on the overhead projector. Do you recall that?-- Yeah.

Your evidence now, I understand, is that the surgeons' reports - is it still your evidence that the surgeons' reports don't accurately reflect the operations you observed?-- That's right.

Thank you. Nothing further, Commissioner.

COMMISSIONER: Thank you.

WITNESS: I just want to say about the guidelines, there are differences between Europe and English guidelines. Europe are somewhat a bit different, but in general it is the same here.

COMMISSIONER: We use the English guidelines, do we?-- That's right.

And also in South Africa, the English guidelines are used?-- Yeah.

Doctor, I wanted to raise something that doesn't really come out of your evidence so far and an entirely unrelated point. I think anyone hearing you speak would realise you weren't born in Australia. Have you found, since the Patel issue came up in the papers, any difficulty dealing with patients who identify you as an overseas-trained or foreign trained doctor?-- No, I haven't experienced it myself.

Are you familiar with other medical practitioners who, if I can put it this way, don't look as if they are Australian born, who aren't Anglo-Saxon or of European heritage who have that problem?-- I have heard it via the grapevine but I didn't experience it myself.

Thank you. Nothing arising out of those questions? Doctor, thank you so much for your time, coming along and giving your evidence so frankly and clearly. We appreciate your assistance very much and you are excused from further attendance?-- Thanks.

WITNESS EXCUSED

COMMISSIONER: And we will now take lunch till 2.30.

THE COMMISSION ADJOURNED AT 1.31 P.M. TILL 2.30 P.M.

THE COMMISSION RESUMED AT 2.35 P.M.

COMMISSIONER: Mr Atkinson?

MR ATKINSON: Commissioner, the next witness is Dr Dawid Smalberger. I call him.

COMMISSIONER: Yes.

DAWID SMALBERGER, SWORN AND EXAMINED:

MR ATKINSON: Witness, your name is Dawid Smalberger?-- That's right.

And Dawid is spelt D-A-W-I-D?-- That's right.

And Smalberger, S-M-A-L-B-E-R-G-E-R?-- That is correct.

Now, you're a doctor at the Bundaberg Base Hospital?-- That's right.

Dr Smalberger, you've prepared a statement for the Commission?-- Correct.

Could I show you this statement? Dr Smalberger, is that your name and handwriting on the statement?-- That's correct.

And is that your statement?-- That's right.

Are the contents true and correct to the best of your knowledge?-- Yes.

Doctor, can I take you through the statement? In paragraph 1 and 2 you explain something of your background. You have a Masters in Internal Medicine from South Africa?-- Correct.

And you've been registered in South Africa as a physician since 2000?-- That's correct.

First registered as a doctor in Queensland in May 2003?-- Correct.

And you've received permission to sit for the Royal Australian College of Physicians examination?-- That's right.

So that would make you a, if you passed that exam, you would be a Fellow of that College in Australia?-- That's right, once I pass the Royal Australian College of Physician examination.

At the moment you work in the Department of Medicine at Bundaberg Base Hospital?-- Correct.

And your line manager, if you like, is Dr Miach?-- That's right.

Now, you'll be aware, of course, sitting in while Dr Berens was giving evidence, that we were talking about Dr Kemps?-- That's right.

You were involved in the treatment of Mr Kemps?-- That's right.

And your first involvement was when he came to the hospital having been referred, I think, by his general practitioner, Dr Crane?-- That's correct.

When he was referred to you, he was complaining about having trouble swallowing?-- Yes, when he swallowed, food got stuck in his oesphagus.

Now, if I can take that up then, we're really at paragraph 4 of your statement. The first thing that you did, I understand, was an endoscopy?-- Just repeat that question?

The first thing that you did within the Department of Medicine at Bundaberg Base when Mr Kemps presented was to perform an endoscopy?-- That's correct.

Can you tell the Court what the endoscopy revealed?-- It showed a mass at the lower end of the oesphagus at the junction between the oesphagus and the stomach, the mass was partially obstructing the lumen of the oesphagus and when it was on contact with the scope, it oozed some blood, and on going past the mass into the stomach and on turning the tip of the scope back up on to see that some of the tumor was also present below the oesophageal sphincter and we took a biopsy, several biopsies to get a histological diagnosis.

Now, the sphincter's at the junction of the oesphagus and the stomach?-- That's right.

What's the significance of finding that part of the mass is below that sphincter?-- Sorry, just repeat that question?

What's the significance or is there any special significance of finding out that a part of the mass is below the sphincter?-- The question then would arise is that primary oesophageal cancer or primarily gastric or stomach cancer.

It might have been a stomach cancer that happens to have spread into the oesphagus?-- That's correct.

Now, were you able to work out the truth of that issue through the endoscopy?-- The true origin?

Yes?-- No, no, I couldn't determine that by endoscopy.

Did you learn how big the mass was through the endoscopy?-- Yes, one could determine that.

And how big was it?-- If I recall correctly, my notes indicated that the mass was at 40 centimetres and if I recall correctly, it was about three to four centimetres in size.

So it was 40 centimetres along the oesphagus and about three to four centimetres in length, I guess?-- That's right.

Now, you ascertained through the histology that the mass was malignant?-- That's correct.

And then you carried out a CT scan of the chest?-- Yes. Once that was then done in as part of the staging procedure for the cancer, that's the staging itself is usually not done by a physician in the Medicine Department, but we often if we plan to refer the patient on to another specialist, we would as a courtesy do the initial investigations that we know that person will need for further decision-making, and in that setting we requested the CT scan of the chest and the abdomen to help with further staging and also asked for an echocardiogram which is a sonar of the heart.

Right. Now, with the staging, is this right, that what you're doing with that is working out how far advanced the cancer is?-- That's correct.

And with that information you work out the most - the optimal procedure?-- Right.

If, for instance, the cancer's metastatic so that it's spread through the body, then in that case there wouldn't be any point to taking out the primary cancer?-- That's correct.

Because there'd still be cancer elsewhere in the body?-- That's correct.

Now, the CT scan, is it performed at Bundaberg Base or is it performed elsewhere?-- It is performed at Bundaberg Base Hospital.

Now, the CT happens; do you get the results personally?-- Yes, at Bundaberg Base Hospital we don't have a radiologist and we rely on reporting of all our X-ray films and CT scans, we rely on a private radiologist in town, so the films have got to go to one of the private hospitals first, be viewed and reported and only then would we receive a report back.

So the CT scans are physically taken in Bundaberg Base but they're interpreted elsewhere?-- That's correct.

And then the results come back to you and that's the first time you see them?-- That's right.

Did you receive the results of the CT scan soon afterwards?-- It was received, I cannot recall exactly when that was received, I don't have a memory of that.

Could you have a look at this document, Dr Smalberger? If you

look at your screen, it should appear there. Now, if we just start at the top, so that seems to be dated the 10th of December?-- Yep.

And highlighted by myself the bits that appear to be medically significant but don't confine yourself to them. Are those - is that the CT results and did you receive them?-- Yes, that is the CT report of the CTs that we've arranged and we probably did receive it, I cannot clearly recall that, but we probably did receive it, although I wouldn't know exactly on what day that was received.

Now, what do you glean from reading that report?-- The highlighted parts, they, if I look across them, indicates that there is next to the trachea, enlarged lymph nodes. Also where the trachea splits into the left and the right main branches, going to the left and the right lung just below that there is some enlarged lymph nodes and also in the lung itself in the right lung in the lower lobe there seem to be four intra-pulmonary lesions indicating that there was four shadows present in the right lower lobe which shouldn't be there and in the periphery of both lungs close to the pleura, the pleura is the membrane that covers the lung close to the surface, and further of the lung, there's several small shadows seen as well on both lungs.

That information interpreted in combination with the endoscopy results, is this right, that it suggests to you that the cancer's not confined to the oesphagus?-- That's correct.

I might ask if we can scroll down a bit further and then maybe over the page. Now, you agree that conclusion follows quite simply from the premises, is that right, that it looks like the patient has a metastatic cancer?-- Yes, certainly one can say that.

All right. Well, do you think you may have seen this document at the time of giving treatment?-- Yes, I'm sure I must have seen it, I cannot clearly recall that now but I'm sure I did view that.

COMMISSIONER: Doctor, what would your view, if you can express one, be of a prognosis of a patient with a cancer of this size and nature?-- That's a question we are often asked by patients as to how long we got to live.

Yes?-- And that's a very very difficult question to clearly answer and my experience is that we're mostly wrong in trying to predict that, but still, one does try to give a approximate indication to the patients and their family and I tend to myself rather than say six months or a year, I would usually advise the patient and the family that we're talking in weeks or we're talking in months or we're talking in terms of years, and in putting it that way, one doesn't commit yourself to a specific number, but still you give the patient and family a rough indication as to what to expect, and I would say in Mr Kemps' circumstances, I think looking at a period of six to 12 months probably would have been what I would have advised him

and his family.

Does it follow from that that there is at least a reasonable likelihood that he would still be alive today if he hadn't had surgery?-- Yes, a possibility.

MR ATKINSON: Doctor, armed with that information and that view, what steps did you take vis-a-vis the patient?-- Just repeat that question?

Did you speak with the patient about your diagnosis?-- Yes, absolutely, I think in the hospital chart it is clearly indicated and in the progress notes that we talked to the patient and his family on the 9th of December and discussed with him the findings and the diagnosis as well as the options that we suggest.

Now, you said you had a conversation on the 9th but the CT results are dated the 10th; do you know how that might come about?-- I think that when I refer to the 9th, that was after the endoscopy it was discussed, the findings of the endoscopy, and you're right, it was only following that that the CT scan was done, but so obviously we didn't discuss on the 9th the findings of the CT scan.

Right, but on the 9th you may have discussed the good reasons for transferring to Brisbane?-- Yes, that's also I think clearly indicated in the progress notes that clearly documented that our advice was that we advise a transfer to Brisbane.

All right. And that was even after just the endoscopy results?-- That's right.

Why would you recommend a transfer to Brisbane?-- My feeling was that we don't have the - we don't have an oncologist in Bundaberg at the Base hospital. He definitely, I thought, would need both a surgical opinion as well as an oncologist's opinion and then also looking at further treatment, taking into account his other diseases that he had, my feeling is that he wasn't a good candidate for an oesophagectomy.

He wasn't?-- I didn't think so.

What are the factors in forming that view?-- He, for instance, had impaired kidney function, his blood tests showed elevated urea and creatinine then which indicated that he has already lost more than 50 per cent of his kidney function and that does impact on treatment, for instance, when we - when we arranged the CT scans for staging, we had to give him medication to protect his kidneys against a contrast medium. When you do a CT scan, contrast medium is injected intravenously and that contrast medium, of course, can cause acute renal failure, more so in somebody who's already got impaired kidney function, so we had him, in preparation for that, we had to give him medication called Acetylcysteine to protect his kidneys from acute renal failure when the contrast is given and that was one of the reasons why he wasn't

immediately transferred to Brisbane either because we first had to give him that medication to protect his kidneys and then did give the contrast and do the CT scan.

When you started on him, was the renal problems one of the factors that make him an unsuitable candidate for an oesophagectomy?-- I wouldn't say that alone would make him unsuitable, but it would certainly put him in a high risk group for major surgery.

His age was another factor?-- Age would be another factor as well and he also had an enlarged heart and the combination of all of those factors I think definitely made him a high risk surgical candidate.

Did you give any serious thought to an oesophagectomy occurring in Bundaberg for Mr Kemps?-- No, I didn't, as it was indicated in the notes on two occasions, the overall goal was for him to be transferred to Brisbane and that's what we discussed with the patient and his family as well.

All right. Now, did you have a view on whether Bundaberg was an appropriate place for oesophagectomies?-- I didn't have a clear view on that. Oesophagectomies is surgery and surgery is out of my field of expertise and I do have a clear view on that but if I can just limit my comment to this particular specific of oesophageal cancer, my feeling would have been that the proper thing would be to transfer him to Brisbane to get an oncology as well as a surgical opinion there.

And you were very firmly of that view, I understand?-- Yes, that was what we decided on and what we documented in the chart.

Yes, sometimes in medicine as in the law there must be difficult calls, but in this case you were thinking that's an easy call, that's obviously the appropriate way to go?-- Yes. I think when one looked at the treatment of oesophageal cancer in general, it's not always black and white, it can be a difficult call exactly what the best treatment is and if one looks through across the world in different places they may do different things, there's not really a standardised protocol that you would, for instance, have in the treatment of breast cancer, there's a bit a large grey area in the treatment of oesophageal cancer and different approaches in different parts of the world.

But having said that, you're in no doubt that the appropriate course in this case was to send this man to Brisbane?-- Yes, that's correct.

And I see in paragraph 5, the last sentence, your view was that the appropriate treatment was a conservative one subject to what an oncologist or another Brisbane expert might say, namely, put a stent in the oesphagus so that the food can go through and you provide chemotherapy or radiotherapy?-- That's right.

COMMISSIONER: Doctor, at this time you've mentioned already that your line manager, as it were, is Dr Miach?-- That's correct.

At this time, were you aware of any reservations that Dr Miach had regarding the reliability of Dr Patel as a surgeon?-- Yeah, I first became aware of concerns in that regard between Dr Miach discussed his concerns with the management of renal patients and the Tenckhoff catheters as well as AV fistulas. My feeling at that time was that it - the concerns was limited to those specific activities.

Right?-- I wasn't really aware at that time of any further concerns and even as time went by, I must honestly say I wasn't really aware of any major concerns otherwise about his work. The term "Dr Death" I heard for the first time when I read it in the newspaper.

I simply ask you that question because I want to make sure that your decision not to have Mr Kemps referred to surgery in Bundaberg wasn't in any way influenced by concerns about Dr Patel, it was simply your clinical judgment that the best thing for this patient is that he be transferred to Brisbane for the sorts of procedures, the sort of conservative procedures you mentioned?-- Yes, I think a pure clinical decision, it wasn't influenced by any rumours that I've heard or any concerns.

Thank you.

D COMMISSIONER VIDER: But you're really only seeking Dr Patel for his opinion because you knew what the process would be, they would ask you had you made contact with a Bundaberg surgeon; is that correct?-- Correct. As I mentioned in this statement, often if we refer a surgical kind of patient to Brisbane.

Yes?-- Then they usually ask has the local surgeon seen the patient too and has he agreed to the transfer.

Mmm?-- And in preparation for the transfer, I've ordered my junior to refer the patient to the surgical department. When we do, when we give an order like that for a referral to a surgical department, it depends on which of the surgeons is on call on that day to receive the referral. In this case I think one can maybe say unfortunately Dr Patel was the surgeon on call and then he did see the patient after that.

And you were not aware as we have become aware that when Dr Patel was asked for an opinion, he didn't come back to the referring doctor with an opinion, he appeared to take over the management of the patient?-- That's correct. He saw the patient, made notes in the file but he didn't actually come back to me personally and discuss the case with me as such, he - from reading the notes, it appears that he had discussed the options with the patient and he's written - he got consent for the patient for the procedure and after that I lost contact actually with the case.

You were not aware that that was Dr Patel's form of behaviour when offered a referral at the time of asking him to see Mr Kemps?-- No, no.

D COMMISSIONER EDWARDS: You make the comment in your statement that you were called unexpectedly to advise a CT scan showed the patient's spleen was in two pieces?

MR ATKINSON: That's a different patient, I think, Commissioner.

COMMISSIONER: That's later on.

D COMMISSIONER EDWARDS: I'm sorry, I thought you had finished. I'll come back to that.

COMMISSIONER: Yes, there's no sort of subheading dividing one patient from the other.

MR ATKINSON: Dr Smalberger, can you look at this document?

COMMISSIONER: Mr Atkinson, just so we don't lose track of things, I'll have the CT scan report concerning Mr Kemps of the 10th of December 2004 marked as Exhibit 131.

ADMITTED AND MARKED "EXHIBIT 131"

MR ATKINSON: Thank you, Commissioner.

Dr Smalberger, this is a note that seemed to come from the surgical ward and I think it's dated the 14th of December?-- Mmm-hmm. No, I just need to correct there, Roy Nicholls was actually my junior doctor and this was - this is a letter written by my junior doctor.

At that stage it seems as if a decision has been made to head towards surgery?-- That's right. If one looks at this letter, that does appear to be the case and I'm not sure why the other decision came along, as indicated in the notes on the 9th and the 10th and very clearly documented there that my wish was for the patient to be transferred to Brisbane.

All right?-- It appears - and after I look back in the chart, it appears that after Dr Patel saw the patient, he then decided to rather take on the surgery in Bundaberg and my junior went along with that and I think this is what this letter reflects.

Right?-- Yes.

So to come back to - you can turn that off, thanks. To come back to what Commissioner Vider was asking you, you didn't just transfer Mr Kemps directly to Brisbane yourself?-- No. As I've mentioned, it's usually necessary to - to get the surgical department to - that they would agree to such a transfer, so that if we do contact Brisbane, that we can tell them that the local surgeon who saw the patient was in agreement and ask them to accept the patient in Brisbane.

So for that reason you transferred Mr Kemps to the surgical department, surgical ward?-- No, he - looking back in the chart, it seems what happened, that after - Dr Patel still saw the patient while he was in the medical ward, then the patient was discharged home and after a - after a couple of days he was re-admitted to the surgical ward and then the surgery went ahead.

And as you said, you weren't consulted. Dr Patel didn't refer back to you personally to discuss-----?-- That's correct.

-----possible procedures?-- Yes, he didn't - he didn't get back to me. I would have preferred that definitely. I think from the - from the notes that my team has made, I think it must have been quite clear on two days in a row that we documented that the plan is to transfer him to Brisbane and I would have expected that if Dr Patel didn't go along with that, with that plan, and he had an alternative plan, that he would have definitely come to me and discuss that to say that he differs from my viewpoint and feel that we would rather attempt the procedure in Bundaberg. I would have preferred - I think it would have been good - good conduct from him to do that.

The records disclose, I imagine, that your department had ordered a CT scan?-- That's right.

And the operation wasn't done until the 20th of December. So, in the ordinary course, you would expect that the CT scan results of the 10th of December had made their way back to the hospital?-- Yes, I think one can safely say that by the 20th of December that radiologist report would have been back at the hospital and would have been in the file.

And the dark shadows in the lungs that the CT scan refers to, they're a strong indication, as you say, that the client - the patient might be metastatic?-- Yes, I think both the enlargement in those paratracheal and subcarinal and in the lungs would have led one to believe that, yeah.

If that's true, an oesophagectomy doesn't serve the purpose?--

It may have served the purpose of relieving the obstruction that resulted in food getting stuck but it certainly would not have done much in prolonging life or curing the disease.

COMMISSIONER: Would a stent in the oesophagus have achieved the same outcome in terms of allowing food to go through the throat?-- Yes, I think one can say that would achieved much the same, and also changing the diet from eating solid food to pureed food for instance.

I assume the process of inserting a stent would be a lot less invasive and a lot less risk to a patient who had a number of other-----?-- Absolutely. It would have been a much less invasive procedure, a relative simple and straightforward procedure.

MR ATKINSON: The stent is inserted through keyhole surgery?-- It is inserted also by endoscopy with a fibre optic endoscope.

Either one or both?

COMMISSIONER: Just down the throat?-- Yes, you insert it down the throat and, yes.

MR ATKINSON: Now, if I can take you to paragraph 9 of your statement, you are no longer dealing with Mr Kemps but you deal with a patient who we've identified in the Commission as P51. Perhaps you could just tell us a little bit about that altercation you had with Dr Patel. I should say we have heard some of the story from Dr Miach but it is more first-hand from you?-- All right. This patient was admitted to the hospital with a heart attack. Upon examination of the patient we noted that his haemoglobin was quite low. He wasn't that old a man. He was approximately 55 years old if I recall correctly, but he had a haemoglobin that was quite low, which means he's anaemic. And when - in the treatment of heart attacks, we give a lot of drugs that thin the blood to prevent further blood clots from forming, both aspirin and injections under the skin that thins the blood. Now, a problem arose here in that we were wondering why his haemoglobin was that low. We were concerned whether he was losing blood internally anywhere. If that were the case, it would have been a different - very dangerous treating his heart attack with blood thinners as that would significantly increase the blood loss. In talking to the patient he recalled that he has been involved in a truck accident where the steering wheel hit him on the chest. He sustained a couple of fractured ribs on both sides and that led us to believe that he could have had internal injuries where he was - where he lost blood. The other problematic scenario was that as treatment - as further management of a heart attack, we usually refer these patients down to Brisbane where they - where they have a coronary angiogram done. Usually in that setting they give further medication that thins the blood, medication that makes the platelets less sticky, and if one has any internal lesion where you may still be losing blood from, such treatment with blood thinners would be contrary-----

So, on the one hand you intend to transfer the patient to Brisbane for the angiogram?-- Absolutely.

And on the other hand, before you do that, you think you'll do a CT scan?-- We had to rule out, yes, that he didn't have an internal injury where he was losing blood.

And it's when you sent the patient, I understand, to radiology, that somehow Dr Patel, without any invitation, invites himself to start treating P51?-- Yes, we sent him to this CT scan and very pertinently asked on the request for the CT scan, we asked if there was any - any sign of injury to the patient's spleen. The patient then went down to the radiology department, the CT scan was done and shortly after that I received a phone call from Dr Patel, advising me that the patient has a ruptured spleen and he planned to take him to theatre for a splenectomy. As you mentioned, I haven't actually referred the case to Dr Patel at all and I can only think that he - he was down in the radiology department for another reason; came across the patient. He may have - he may have asked the staff there what the CT scan was about as the patient had at that stage a blood transfusion running. They may have mentioned to him that we were wondering about a ruptured spleen and I think he probably had a look at the CT scan, made up his mind that the spleen is ruptured and then he phoned me.

Does that happen in hospitals, that sometimes a surgeon moves into a physician's turf and says, "I'll handle this", or are there protocols about that type of thing?-- Yes, in general I think you wouldn't see a patient or give an opinion on a patient if the patient hasn't been referred to you formally. That's the usual procedure and protocol. In this case the call that I got from Dr Patel was very unexpected. I immediately mentioned to Dr Patel that I think a splenectomy would not be a good idea in this case. On the phone I advised him that the patient had just had a heart attack and it would be very high risk to take him to theatre. I immediately arranged with Dr Patel to meet him in the ICU and made my way there. Arriving at the ICU, Dr Patel was already there. The CT scan films arrived. We studied that and I pointed out to Dr Patel I don't think there is any problem with the spleen. He was-----

Can I ask you this, Doctor. We have a vague understanding a spleen is kind of a discrete thing. It is in a bag under some kind of pressure so if it's ruptured or if it's in two pieces, it's quite easy to see?-- There is different - different degrees of injury to a spleen. A spleen can indeed rupture completely and come apart in two pieces. In such - such a scenario, there's usually - the patient usually rapidly bleed out. Then the other end of the spectrum is where you get just a tear on the surface of the spleen. In such a case, a patient can lose a little bit of blood into the abdomen, the crack on the surface can seal off with blood clots and, indeed, if it is just a minor crack on the surface of the spleen, we very often just treat it on the surface and allow it to heal up and not do any surgery on it. On the other

hand, if the spleen is in two pieces, obviously in that case the spleen needs to come out and-----

When you - sorry. When you sat down with Dr Patel to look at the CT scan of the spleen, you were very clear that you considered there was no problem with the spleen?-- Yes, I didn't see anything wrong. His opinion was that the spleen was in two pieces. I think he made a mistake in that he - the organ next to the spleen that he saw I think was the upper part of the kidney and that was indeed lying next to the kidney but separate and I pointed that out to him and we got into a bit of an argument. But the - the other point I should mention is that I was also very surprised when the anaesthetist arrived in the ICU and at that point I realised that Dr Patel has already phoned the anaesthetist to come along for - for the surgery. I also talked to the anaesthetist and made my view clear that I don't think this patient should go to theatre, both because he's just had a heart attack and, secondly, I don't think there was anything wrong with the spleen.

In the hierarchy, is this right, Dr Smalberger, that Dr Patel on the surgeon's team is very senior - he's the Director of Surgery - and you in the physician's team, with respect, you were a relatively junior doctor at that time?-- That's correct.

So it wasn't easy to stand your ground I imagine?-- No, it was difficult. Dr Patel obviously has many more years of experience than I - I have. He was the Director of Surgery. I'm just a junior consultant on the medical team and I think for - to make a stand like that, you had to be very sure about your opinion otherwise, obviously, the consequences could be - could be bad for you.

How receptive was Dr Patel to your opinions?-- He wasn't accept - receptive of that at all. He raised his voice, he became angry. In medicine or in general, the patient who - or the doctor who the patient is admitted under, that doctor has sole - sole right to decide what happens with that patient and he's got to solve this question as to who may see this patient or what may happen with that patient. This patient was admitted under my care and even though a more senior doctor tried to convince me of treatment that he didn't need, I was fully within my rights of refusing to allow that treatment and I did refuse this patient to come to theatre. Coming from a junior physician, as I said Dr Patel didn't seem to take that well. As I said, he became angry, raised his voice and then proceeded with some abuse which I took very much exception to and we were - we were basically standing at the foot end of the bed of the patient, were within earshot of the patient as well as nursing staff. He told me that my opinion is the most stupid thing he's ever heard in his life and I very much felt that that was out of bounds, it was unprofessional conduct. I felt it was, as I say, out of bounds and I felt that he needed to take a penalty shot for that.

Now, I'll just get skip along a little bit here, Doctor. In

the event, you did transfer the patient to Brisbane?-- Yes, I refused for him to go to theatre and we phoned Brisbane. We usually transfer our cardiac patients to Prince Charles Hospital. Once Prince Charles Hospital became aware of the difference in opinion about the spleen, they suggested that we rather transfer the patient to Royal Brisbane Hospital where they can have a surgical opinion too. We talked to the ICU at Royal Brisbane Hospital. The consultant on-call there felt that if there was indeed a splenic rupture, that it would be unsafe to transfer the patient by air ambulance and that the splenectomy should be done in Bundaberg. I again refused to have a splenectomy done here. There was further pressure that the splenectomy should be done. We - we finally asked the consultant at Royal Brisbane Hospital to talk to Dr Patel himself. Dr Patel did then talk to him by phone. I wasn't aware what was being said but finally Dr Patel phoned my junior and told him to go ahead with the transfer to Brisbane. So there was quite a flurry of phone calls to and fro there but finally the transfer-----

In the event, I understand the patient went to Brisbane but came back to Bundaberg?-- That's correct.

The radiology showed he didn't have a spleen problem at all?-- That's correct. At the Royal Brisbane Hospital, the first thing when he arrived there, they looked at the spleen and the CT scans and agree that there was nothing wrong with the spleen. He then was taken to the catheter laboratory. He had a coronary angiogram which showed, I think, about a 90 or 95 per cent stenosis of one of his coronary arteries and that was opened with a stent and he came back.

And the fact that there was that conclusion, that would have caused risks in surgery?-- Oh, great risks. It would have been great risks to take him to surgery under that circumstance, yes.

D COMMISSIONER VIDER: Did Dr Patel come back and apologise to you when the patient returned to Bundaberg?-- No, he didn't.

MR ATKINSON: Dr Smalberger, you subsequently raised this issue with Dr Keating?-- Yeah, after the event I went - as I say, I felt that his - I was alarmed both by the incident where he wanted to take a spleen out that was - I thought was normal. We - I think in - like, we're all human beings so we all mistakes, we are all allowed a lapse of judgment, but I think if somebody points out to you that you're making a mistake and then you abuse that person, my feeling was that wasn't - that was out of balance and step outside the line. For that reason I went to see Dr Keating and I detailed the incident to him and also informed him that I want to lay a complaint against Dr Patel and ask for the procedure to do that.

That was in the course of 2003?-- That's right.

Do you remember what month that was?-- If I recall, it was close to Christmas at the end of 2003 but I cannot recall the

exact date.

COMMISSIONER: Is the effect of what you're telling us that had you not intervened and stood your ground very firmly and had Dr Patel been allowed to conduct the splenectomy as he'd planned, this patient very likely may not have survived?-- One can probably postulate about that but I think the most one can say is it would have been extremely high risk to take him to theatre and it could be possible that he could have lost his life with a 95 per cent stenosis of one of his coronary arteries, yeah.

You've already mentioned that you conveyed two separate concerns to Dr Keating. One concern was obviously the concern about the unprofessional way in which Dr Patel behaved towards you, but for the moment I'm more concerned in how clearly you conveyed to Dr Keating the seriousness of the medical situation. Can you recall how you put that to Dr Keating?-- Yeah, I - I explained exactly like I explain now what's happened and what led up to the incident where he made that fateful remark towards me.

MR ATKINSON: And what was-----

COMMISSIONER: Sorry, Mr Atkinson, Sir Llew has a question.

D COMMISSIONER EDWARDS: I just need to ask that question if I could now. Have you in your clinical experience ever seen a patient who has his spleen in two pieces, as Dr Patel, that is not a major surgical injury?-- I've never seen that.

Thank you.

COMMISSIONER: As I understood your description of the CT scan, there was a body which could be recognised as being the spleen and a detached body which you thought was a kidney and Dr Patel thought was another part of the spleen. Have I got that roughly right?-- Yes, that's - that's how I explain it to myself where he made the mistake, yes.

And so, if Dr Patel's interpretation of the scan had been correct, if there was this distinct part of the spleen that had split away from the rest of it, the patient would have been very, very critically ill?-- Yes, I - if one looks at the spleen, it's like a balloon, as you've mentioned, and on the one side the major blood vessels enter the spleen. If that - if the rupture or the tear of the spleen involves the hilum, which is where the blood vessels get into the spleen, where the blood flow is coming, if the tear involves the hilum, that patient bleeds out very rapidly. If the spleen is in two pieces, one would have expected that patient to have bled out shortly after that injury-----

When you say "shortly", within an hour or two hours?-- Absolutely, yes. So this was already a week or two after the truck incident. And when he phoned me, mentioning to me on the phone that the spleen is in two pieces, I immediately questioned that and I couldn't - I couldn't think that the

patient was - with a spleen in two pieces would show up two weeks later. It was just a haemoglobin-----

Indeed. You've also told us of all the to-ing and fro-ing of getting the patient transferred either to the Prince Charles or to the Royal Brisbane. But if Dr Patel genuinely believed he had seen a spleen broken into two pieces, surely he would have been aware within at least 24 hours that diagnosis must be wrong if the patient hadn't bled out?-- Yes, the patient didn't spend that long at the hospital altogether if I am - I'm not a hundred per cent sure how long he spent there but, yes, I agree with you, if the spleen was in two pieces, he would have bled out within an hour or quicker.

Yes?-- Certainly one wouldn't survive for days or weeks.

Yes.

MR ATKINSON: So if he had any experience in splenectomies or spleen problems, as a surgeon he should have noticed that the symptoms being displayed by the patient just weren't consistent. He wasn't bleeding out, he wasn't anaemic; there was no reason to think that he had a spleen that was in two pieces?-- He was anaemic.

Right?-- Yes, he was anaemic. So I think my feeling was that he could have lost blood at the time of the accident but certainly wasn't from the spleen.

And there would have been a much more rapid decline if it was from the spleen?-- Yes.

You've mentioned that just as you've explained to me the condition of the patient you say you explained it to Dr Keating. What was his response?-- Dr Keating listened to what I had to say. His first question was if I approached Dr Patel about the issue. At that time I mentioned to him that I would feel very uncomfortable approaching Dr Patel about the issue due to the hostile nature of the altercation we had. In general, my personality is such that I, in general, tend to avoid conflict. I'm not a vindictive or an aggressive person in general and I put to Dr Keating in that way that I wouldn't want to confront him face to face. Dr Keating then suggested that he would talk to Dr Patel about the issue and I accepted that.

COMMISSIONER: Did you ever get any feedback from Dr Keating following that meeting?-- No, Dr Keating, I believe, then talked to Dr Miach, was my line manager.

Yes?-- Dr Miach took the case further from there. Dr Miach called me in a couple of days later. At that time I realised that Dr Patel has already seen Dr Miach also about this matter. I gave Dr Miach a detailed version of events that happened and Dr Miach then informed me Dr Patel gave a completely different version of events that took place. But Dr Miach then went to take a look at the patient's medical records as well as the CT scan and he came back to me after

that, mentioning to me that he feels my diagnosis and management was correct and that Dr Patel was in error.

MR ATKINSON: That was borne out, of course, Doctor, when the results came back from Brisbane. The radiology made very clear that this man didn't need a splenectomy and it was already clear that Dr Patel wanted to give him a splenectomy. So it wasn't that difficult, is that right, to resolved who was right and who was wrong?-- Yeah, it wasn't difficult.

But notwithstanding that, you never heard anything about it from Dr Keating?-- No, there was no formal feedback, no.

The only feedback you got was from your line manager Dr Miach?-- That's right.

And you don't have any idea whether Dr Keating had any further involvement?-- I cannot say for certain, no.

When you went up to see Dr Keating, was it in your mind to actually fill out a formal complaint?-- At the first meeting I did ask Dr Keating what is the procedure for formal complaint as I wasn't aware exactly what steps to take.

Were you ever given a form or informed of what a formal complaint entails?-- No, I think after we discussed the question about whether I should approach Dr Patel or whether Dr Keating would approach Dr Patel, the plan was then that Dr Keating would discuss it with Dr Patel and it was left at that.

And in the event there's no paperwork?-- No, no paperwork was formally completed.

Just one last question, Dr Smalberger. When a patient comes back from Brisbane to Bundaberg, he's already seen, as you know - as you said, two specialists at the foot of his bed arguing heatedly, what was his level of confidence, like, in the Bundaberg Base Hospital at that stage?-- I happened to see him again in the outpatient department where you get a follow-up appointment still to look at the issue of why he was anaemic. He had - he had a past history of haemorrhoids, and taking his history he also had a history of passing blood regularly, and in Brisbane they also got the same history from him and recommended that the - and further investigation of - that he should have colonoscopy done. When he arrived back from Brisbane, as I say, I happened to see him at outpatient department and discussed the problem of the anaemia and the possible colonoscopy, but the patient was very much against that idea and informed me that he would rather go back to Brisbane to have his colonoscopy done. He was - he was still very much upset by what happened in Bundaberg Base Hospital, as he could - as he could see two physicians arguing at the foot end of his bed, and I think he put it quite well in that he - I think he lost confidence in the hospital. He was given - antagonistic towards me.

He didn't know at that stage whether you were the doctor in the right or the wrong because no-one had told him?-- Yes. I think when you are in the hospital, you're ill, a lot of drugs, painkillers. For instance, a patient with a heart attack is given Morphine. That makes you a bit drowsy, and you are often not sure who plays what role in the hospital and when he came back he said to me, "I never had a ruptured spleen. The guys in Brisbane said I had a heart attack." And so I - and he said that to me in a - as though he's accusing me of having made the wrong diagnosis. I said to him, "I was fully aware that you had a heart attack, and it wasn't my diagnosis at all that you had a ruptured spleen", but I think that explanation didn't mean all that much to him as though - due to the fact that he had - I don't think he knew who made the diagnosis of heart attack and who made the diagnosis of ruptured spleen, and he wasn't confident with Bundaberg Base Hospital and he informed me he would go to Brisbane for the colonoscopy.

That's the evidence-in-chief. Have I tendered Dr Smalberger's statement?

COMMISSIONER: Just so there is no confusion I will make Exhibit 132 the discharge statement dated 14th December 2004 signed by Dr Roy Nicholls.

ADMITTED AND MARKED "EXHIBIT 132."

COMMISSIONER: The statement of Dr Smalberger will be Exhibit 133.

ADMITTED AND MARKED "EXHIBIT 133"

COMMISSIONER: Just on an unrelated question, I'm not sure whether you were in here when I asked Dr Berens about the position of - since this issue has come up in the paper of Dr Patel, having any difficulty with patients who identify you as a foreign trained or overseas trained doctor. Have you, yourself, experienced any problems of that nature?-- Personally, I found the general climate of the media reports for overseas trained doctors - I personally found that very distressing. I haven't had any - any patient approaching me in any inappropriate way in that regard, but I certainly - there certainly are other doctors at Bundaberg Base Hospital that has had unfortunate incidents with patients.

I'd simply like to take the opportunity - I know I have said this on several occasions, but we've had two outstanding examples today of overseas trained doctors, and I just hope the message is getting through that this inquiry isn't a witch hunt into overseas trained doctors, and as we've repeatedly been told, Queensland's health system depends on its 16 or 1700 overseas trained doctors' offerings. We've had two fine examples in the room here today. Mr Boddice, you mentioned that you were appearing for Dr Berens. What's the situation with Dr Smalberger?

MR BODDICE: I understood Ms Gallagher was appearing.

MS GALLAGHER: Thank you, Commissioner. I didn't announce my appearance, my mistake.

COMMISSIONER: Do you have any questions?

MS GALLAGHER: Two questions.

COMMISSIONER: Yes.

EXAMINATION-IN-CHIEF:

MS GALLAGHER: You indicated when Mr Atkinson was asking you some questions that you had seen Dr Keating fob the incident, and I'm specifically referring to matters arising in paragraphs 13 and 14 of your statement. It might be easier for you to turn that up. After you had that conversation with Dr Keating, was - did anything come of it in the sense of was the relationship between you and Patel any different, perhaps?-- I think after that - after that event Dr Patel's

attitude towards me did change for the better. Before that I - I experienced him as - as treating me quite contemptuously at times and quite aggressively and quite arrogant. I told myself that at times the - the American way of speaking and doing things can sometimes be viewed as being overly aggressive and arrogant and, maybe, I shouldn't take it personally, as such, but in general I would think that after that the - Dr Patel's manner and demeanour towards me did change.

Did you attribute that change in demeanour to anything specifically?-- I - I took that to - to Dr Keating talking to Dr Patel. Dr Keating and Dr Patel had a very good relationship, and I attributed that change to talks between them.

Thank you, doctor. Can I take you from your statement now to another matter? The witness has had the chance, Commissioner, to examine Exhibit 101 earlier in the course of the day in the breaks, and I'm, in particular, referring to the records of Ms Daisy. The Commission has heard some evidence about your involvement in that particular patient's care, and I was wondering if you would elucidate for the Commission the actual nature of the involvement you had. I'm specifically dealing with, at least, the evidence that it is in in respect to the admission related to the below knee amputation. Could you tell the Commission what your involvement in that patient's care was in that instance?-- At the time of the hospital admission for the below knee amputation there were several doctors looking after her. She was a complicated patient with multiple problems, and in that setting the surgical team's role was that of the surgery and the below knee amputation. The anaesthetic team saw her before her admission due to - related from the aspect of giving anaesthesia. I saw her before hospital admission in outpatient department to look at cardiac function specifically. She had, in May of that year, a heart attack. The anaesthetists were uncertain about her cardiac status going into this kind of operation. Several tests was - was requested, like echocardiogram, stress MIBI test which is radionucleotide study that were used to assess the profusion of the heart muscle by blood, and my role was to assess cardiac function and the results of these tests and advise the anaesthetists about my opinion about the risk of heart. I saw her before hospital admission in outpatient department. I assessed her heart function and then dictated a letter, which I forwarded to her GP and sent copies to Dr Carter, the anaesthetist, as well as Dr Patel. Once she was admitted to hospital I was called again to see her, as I indicated, in that letter that once she's admitted they must please call me, and I would be - help with the hospital management, as I could see that this is a complicated case that's fraught with possible complications. When she was admitted they did call me. My brief at that time from them was that her blood pressure is very high and they would like me to stabilise her blood pressure before surgery. We did that, and we did it with betablocker, which is a medication that also protects the heart in the setting of surgery. Studies have shown that patients with blocked up coronary

arteries, if betablock is given before surgery and for the period after surgery that that protects them against further heart attacks in that perioperative period, and that's what we did, we protected the heart with betablocker. We brought her blood pressure down, and that was the main role that I played in that management.

In the immediate post surgical period what was the managed care of the patient?-- Immediate postoperative, that was still the role that I played to keep an eye on her blood pressure and her heart function. There was, I think - there was confusion in that I think certain - there's certain perception that I was also at that time looking after her kidneys, but that wasn't actually the role that I - that I played.

But you-----

COMMISSIONER: There was a kidney renal issue that came to light later, and Dr Miach was brought in to deal with that?-- Yes.

And you had no role in managing the patient's wound or stump?-- No, I had no role in the management of the stump and from the renal viewpoint she has been, before that admission, a patient of Dr Miach and she was operated by him in outpatients and also in previous hospital admissions and, as such, the renal aspect was doctor - responsibility of Dr Miach, yes.

MS GALLAGHER: But it came to be the case, didn't it, in a ward round where you were attending for the cardiac purposes that you described that you recommended a referral or review, I beg your pardon, by Dr Miach?-- In doing ward rounds daily, looking at the cardiovascular aspect of her care, I noted that she was deteriorating. I first - I looked for possible causes of that, noted that the renal function was deteriorating and also noted Dr Miach up to that point hasn't been involved in her care, and on the second postoperative day I recommended to the surgical team to get Dr Miach involved. This patient was, again, admitted primarily under the surgeons. I was acting as a consultant from the medical ward. I couldn't - I couldn't refer this patient on to a third doctor, all I could do was recommend that he - the surgical team under whose care she is - I could only recommend to them I think you should get the renal team involved.

And that's because of the precedent you described before in medicine about how referrals work and who, in fact, the patient is admitted under, having determined the criteria about treatment and care?-- Exactly. The primary doctor, the first doctor the patient is admitted under, he is deciding exactly who should look after that patient, and for that reason I asked on the first - on the second postoperative day I requested the surgical team to get Dr Miach involved. By the next day I have noted it hasn't happened yet, and then my team were there, and to make a direct referral to Dr Miach.

Thank you, doctor. I have nothing further, Commissioner.

COMMISSIONER: Thank you. We might take a five minute break.

THE COMMISSION ADJOURNED AT 3.44 P.M.

THE COMMISSION RESUMED AT 3.59 P.M.

DAWID SMALBERGER, CONTINUING:

COMMISSIONER: Mr MacSporran?

MR MacSPORRAN: There's just a small housekeeping matter, if I could raise it at this stage. I have no questions for Dr Smalberger.

COMMISSIONER: Yes.

MR MacSPORRAN: The witnesses who are to come next and following are ones that do interest my client, that is, Mr Gaddes, Ms Hunter, Mr Martin and Ms Ray and Ms Kirby. I can't be here tomorrow. I am in Brisbane. I simply can't shift, and I have to leave in about half an hour. I'm just wondering whether you would grant me the indulgence to allow me to cross-examine those witnesses Thursday.

COMMISSIONER: Indeed, I don't have a problem with that. Mr Andrews?

MR ANDREWS: It won't inconvenience the inquiry staff. It may involve some inconvenience for the particular witnesses, but they're all Bundaberg residents.

COMMISSIONER: Thank you, Mr Andrews.

MR MacSPORRAN: I can say it will be brief, brief questioning.

COMMISSIONER: Mr Allen?

MR ALLEN: It might only inconvenience the witnesses, but these are working nurses and arrangements are made in operating theatre and ICU for their duties to be taken over by other persons. Arrangements are being made for, at least, two of those witnesses for today and tomorrow.

COMMISSIONER: Yes.

MR ALLEN: It does only inconvenience them, but it inconveniences the hospital.

COMMISSIONER: Well, we will do everything we possibly can to accommodate their convenience. I think there's only one restriction on that, and that is I've been prohibited by counsel assisting from sitting late tomorrow evening by reason of a football match. Subject to that we will try and fit in with those witnesses, even if it means starting early and finishing later or doing whatever is necessary.

MR ALLEN: Thank you, Commissioner.

COMMISSIONER: Yes. Now, does anyone have any questions for Dr Smalberger?

MR MULLINS: Yes?

MR MULLINS: Thank you, Commissioner.

CROSS-EXAMINATION:

MR MULLINS: Dr Smalberger, my name is Mullins. I appear on behalf of the patients. Can I ask you to look at paragraph 9 of your statement? This is the issue of patient P51. You mentioned that your discussion with Dr Keating occurred, to your recollection, in about December of 2003?-- Yes, I am not sure about the exact date, but it was soon after this incident occurred.

Right. So the meeting occurred soon after the incident occurred?-- That's right.

And the meeting occurred in about December 2003?-- That's correct.

So the events unfolded in, can we say, November or December 2003?-- Yes. If I could recall, it was close to Christmas 2003.

You mentioned in your statement and your evidence that Dr Patel called you unexpectedly and advised that the CT scan showed the patient's spleen was in two pieces and that he had decided to do an urgent splenectomy. To your recollection was there any record in the chart of this patient to record Dr Patel's decision?-- Sorry, just repeat the question. You are asking me if Dr Patel made any notes in the chart?

That's correct, or is there any note in the chart or the records that the Commissioner could look at to see that Dr Patel's decision to recommend a splenectomy to the patient was recorded?-- I looked over the records in preparation for this sitting and I think you are correct, I couldn't pick up any notes that have been made by Dr Patel. The only reference I found was on the discharge summary where the - either the discharge summary or letter referred to Brisbane was mentioned may have had possible ruptured spleen, and in brackets was

written "according to Dr Patel".

That was on the discharge summary?-- It was either discharge summary or the discharge page where handwritten discharge summary is made on.

To your knowledge the discharge summary was extracted to a large accident from the body of the file?-- That's correct.

You mentioned in paragraph 10 that Dr Patel had not only made the decision, it appears, to conduct this urgent splenectomy but had, in fact, organised an anaesthetist. Is it likely that - or to your knowledge had the patient consented to the surgery before the anaesthetist had been organised?-- I think - I'm not - definitely not aware the patient signed a consent. I think, looking at the times - at the sequence of events how rapidly it occurred I wouldn't think there would have been time in that space for Dr Patel to have talked to the patient and asked for consent.

You mentioned that the patient was primarily admitted under your care and you refused to allow him to go into the surgery?-- That's correct.

And you mentioned that the general protocol is that the sole discretion of treatment is held by the - the surgeon or the doctor to whom the patient was admitted; is that correct?-- That's correct.

Now, is there a record of that protocol somewhere? Queensland Health document or-----?-- Not that I am aware of. I am not aware of that being in writing, it is just a general understanding in the medical world, I think.

Did Dr Patel, in your discussions with him, appear to be familiar with that type of protocol?-- I would expect him to be familiar. I am not sure whether - I would be very surprised if there is a different system in operation at places where he has worked at before.

COMMISSIONER: And he must have accepted it ultimately, even if reluctantly, because he allowed you to remove the patient from his proposed surgery?-- Yes, I think one can deduct from that that he did accept that I had authority over the patient, yeah.

Yes.

MR MULLINS: In your subsequent discussion with Dr Keating, did you point out to Dr Keating that Dr Patel, at least in the first instance, hadn't consulted you prior to organising this splenectomy?-- I can't recall the exact details of my discussion with Dr Keating. That was, what, December 2003, so the details in my memory in that sense would be very vague. I cannot answer that confirmatory.

We will come back to that discussion in a moment. Can I ask you some questions about the CT Scan that both you and Dr Patel looked at together-----?-- Yes.

-----in determining whether there was a need for this splenectomy. Was there a report?-- There eventually would have been a report, although, as I have pointed out previously, at Bundaberg Base Hospital we don't have a hospital radiologist. Any X-ray, or ultrasound, or CT Scan is outsourced to a private radiologist in town and that process can take quite a while to get a report back. So very often it would happen that we, as clinicians, would look at the X-rays ourselves if we need to make immediate decisions. And I think that's a big problem at the Bundaberg Base Hospital, that we don't have an on-staff radiologist and we are taking ultrasounds, X-rays and CT scans, all kinds, and the onus is really on the clinicians to interpret that when they have got to make immediate decisions.

In the ordinary course of things, is a written report prepared by a radiologist?-- That's right, the radiologist would look at the films, prepare - they usually dictate their report on audio tape and then it is typed out, and once it is typed out is forwarded to the Base Hospital. And that process can be fast, it can be slow. It is a system that in general, in my opinion, doesn't always work that well, and it would be of great relief, I think, for all clinicians at Bundaberg Base Hospital, if that can be corrected, as I think that makes opportunity for mistakes being made.

When you looked at the CT scan there was no doubt in your mind

that there was no problem with the spleen?-- That's correct.

That the patient was subsequently referred to the Royal Brisbane Hospital and you have told us they confirmed your view. That's correct?-- That is correct.

Do you know whether there are any further CT scans taken, or was it simply the patient simply interpreted - I am sorry, were the CT scans that you and Dr Patel simply reinterpreted by somebody in Brisbane?-- Yes, the CT scan accompanied the patient down to Brisbane and they would have looked at that to come to a conclusion.

So to your knowledge there was no further CT scans done to provide greater detail or a greater clarity of picture?-- Not to my knowledge, no.

Now, when you had your discussion with Dr Keating, did you point out to Dr Keating that in terms of Dr Patel's clinical competence that he had simply misinterpreted the CT scan?-- Again, as I mentioned, I cannot recall the exact details of my conversation with Dr Keating at that time. I can recall mentioning to him the whole sequence of events, but looking back I can just cannot recall exactly the words I said to him and what I didn't say to him.

Well, you have stated in your statement and you have confirmed today in your evidence that there were two issues. One was the clinical competence issue?-- Mmm.

That was really the foundation for the second issue, being his unprofessional conduct to you?-- That's right.

In circumstances where retrospectively you can demonstrate clinical incompetence on his part, that's correct?-- Yes, I think that would have been the thrust - general thrust of the conversation, definitely.

When you approached Dr Keating, you intended to make a formal complaint?-- That's right.

And you felt that this was sufficiently serious to reduce to writing in a formal complaint?-- Yes, I think I was definitely alarmed by the clinical decision making in wanting to take a patient to theatre, a patient who has just had a heart attack and who was misdiagnosed with a ruptured spleen, and I also felt professional conduct was out of bounds.

At that time, what was your understanding of what the complaints procedure was in those circumstances?-- I wasn't sure what the exact procedure was for the complaints. I arrived here in Australia in - I started working in June of that year at the Base Hospital and, as it occurred some time in middle or late December of that same year, I was still very new, really, to Australia and I still wasn't fully versed in how things are done in Australia in general, and that is why I think I went to see Dr Keating and asked him the procedure for that.

When you arrived in Australia and commenced working at the Bundaberg Base Hospital, did you receive a booklet or a guide that described to you how the various complaints procedures and other procedures at the hospital worked?-- There was - I did receive an orientation handout that was more aimed at the clinical work and clinical procedures, so that handbook was given to me but that didn't provide - if I can recall correctly, I didn't receive anything specifically on procedures for laying complaints, no.

Other than Dr Keating, was there any other person at the hospital who handled complaints, to your knowledge?-- Yes, I tried to think back why I specifically went to see Dr Keating; why not, for instance, my line manager, Dr Miach. If I recall correctly, Dr Miach was actually on holiday at the time. He usually takes, around about Christmas, one or two weeks off, and that could be one reason that I just need to confirm. I think the other reason is that I always found Dr Keating very approachable, his door was always open, and if there wasn't anybody with him in the room, I just knocked on the door and if he wasn't seeing anybody at that moment, at that time, he would wave me in and we would have a talk. It could have been any of those reasons why I approached specifically Dr Miach - Dr Keating.

At paragraph 14 of your statement you state that Dr Patel - you were advised by Dr Miach that Dr Patel had given a different version of events that occurred. Were you informed of what that version was?-- No, he didn't mention to me exactly what version Dr Patel gave. Dr Miach just said Dr Patel gave a different version, but from his experience that is the way things work in argument, you get two different versions, and that he would investigate it further to see who was actually giving the correct version of events.

Thank you. Nothing further.

COMMISSIONER: Thank you, Mr Mullins. Mr Allen or-----

MR ALLEN: No, thank you, Commissioner.

MR DEVLIN: I have a very short matter.

COMMISSIONER: Yes, Mr Devlin.

MR DEVLIN: Thank you.

CROSS-EXAMINATION:

MR DEVLIN: Dr Smalberger, my name is Ralph Devlin and I represent the Medical Board of Queensland. Can I just go to the second paragraph of your statement, is what I wanted to ask you about. You qualified as a specialist in 2000 in South

Africa and came here in May of 2003. And it appears you have spent all of your time in Australia here in Bundaberg?-- That's correct.

You have gained the general registration under Area of Need at the deemed specialist registration, is that right?-- That's correct.

But you are also - I gather that you are also in the process of obtaining the Fellowship of the Royal Australian College of Physicians?-- That's correct.

In the time that you have been here, has there been any particular practical or professional barrier to the gaining of a fellowship? For example, we heard from Dr Berens that he went to a couple of centres where they weren't approved centres for the gaining of the requisite experience. Have you struck that with your posting at Bundaberg, or have you been able to gain that approval from the college?-- Yes, Bundaberg is - I think is a centre where you can get experience. Once you apply to the specialist college, you have your experience - your training and experience assessed.

Yes?-- They - you go through quite a rigorous assessment process.

Yes?-- Having to provide them with quite extensive documentation, starting with a detailed document on the exact training that you had in your country of origin. Then they require a lot of detail, almost from month to month exactly what you have done in your training, the names of the heads of your department that you received your training from, their contact details. From there, your practice experience, where you have worked, referees. And so that's quite a lengthy process, to go through that. Once they have received and evaluated all those documents, they then invite you for an interview. I have - like, I had to go to Brisbane and two of the members of the specialist college interviewed me. They again went over all the documents that they received, asked additional questions related to those documents to fill in any details that they wanted to know. Once - once that process is completed, they then appoint three supervisors who would be three specialists working with you, and they then set up a 12 month peer review program that you have got to complete during those 12 months. The three referees give reports to the specialist college on a three-monthly basis, structured reports that they have got to complete and forward to the college. If you satisfactorily complete that 12 month peer review program, they then recognise your training and experience as being satisfactory for practice in an Area of Need and equal to the performance of Australian specialist. And at that stage, they then give you permission to sit the Fellowship exam or the college specialists exam, which if you then successfully complete that, you can apply to become a Fellow of the specialists college.

So you are in the process of going through that procedure?-- Yes, I have completed the 12 month peer review program and I

received permission to sit the specialist college exam.

Thank you. You would regard the process that you have just described as quite rigorous?-- I thought it a very rigorous process, very detailed process, yes.

As an overseas-trained doctor, trained, as you are, in South Africa, are you conscious of any particular disadvantage that you suffer, whether practically, whether because of where you are in Bundaberg, or any other factor that you could point to, or is it simply a rigorous process that you accept-----?-- The only inefficiency I think is Bundaberg isn't a recognised training facility for specialists. We at Bundaberg don't have what we call registrars, who are specialists in training. We don't have - we don't have positions at that level.

So how is that overcome? In your case, how was that overcome?-- Well, actually, in my case I didn't specifically need any further training but I receive - if you needed any further training, that would be - Bundaberg would be a place where you cannot get that training. You would need to go to another centre.

Yes?-- Once you have completed the 12 month peer review program, the college can either decide that your level of performance is unsatisfactory and not equal to Australian specialist, or they may decide that you performed satisfactorily but you need further training, or they may decide that you don't need further training but you just need to write the final exam, or the other possibility would be - would be that they would decide that they would outright give you fellowship without any further requirements. That is another option.

Is Dr Miach one of those who has participated in the peer review or are you talking about three other-----?-- No, Dr Miach was one of my peer review.

Are the other two based in Bundaberg or are they elsewhere?-- No, the one other was Dr Judy Williams at the Bundaberg Base Hospital.

At the?-- Bundaberg Base Hospital.

Yes, thank you?-- And Dr Llew Davies, who is a physician at Rockhampton who I deal frequently with through my involvement with the teaching of medical students here in Bundaberg, and he was also named as well as one of the supervisors.

My last question is this: as a deemed specialist within the hospital system then, is there any formal supervision of your work by anyone else? Do you see yourself as being subject to formal supervision, or not?-- You know, once you have completed-----

I don't mean in the context of the fellowship, gaining the fellowship of the college?-- Outside the peer review program?

Yes, just in terms of the hospital structure. Are you somebody who is nevertheless subject to formal review or formal supervision?-- Yes, I would still regard myself being under the supervision of Dr Miach.

Thank you?-- Yes.

So he is your supervisor in his position as Director of Medicine?-- Exactly.

Thank you.

COMMISSIONER: Just if I can follow up on some of those questions from Mr Devlin, in a sense it is an advantage for you, I take it, that you're in a department which is headed by a fully qualified Australian specialist in Dr Miach. That makes it easier for you in terms of the college requirements?-- Yes, I think working with a physician of Dr Miach's stature, I think that's certainly an advantage, and a privilege, I must say.

If, for example, you were a junior surgeon that had come from South Africa and you were working in the surgery department under Dr Patel, it would be much more difficult to satisfy the Australian College of Surgeons' requirements because you weren't working under the supervision of a qualified Australian surgeon?-- Yes, I certainly - I certainly would agree with that.

Yes. Who is next? Mr Diehm?

MR DIEHM: I suspect it is to me, Commissioner.

COMMISSIONER: Yes.

CROSS-EXAMINATION:

MR DIEHM: Doctor, I am Geoff Diehm and I am counsel for Dr Keating. The matter that you took to Dr Keating concerning patient P51, you have described for us what the nature of your discussion was and what the outcome of it was, including what you infer to have happened after you met with Dr Keating. Your inference is that Dr Keating spoke with Dr Patel because there was an improvement in Dr Patel's attitude towards you subsequently. Are you able to say whether or not at that point in time you were satisfied with the way in which your complaint to Dr Keating had been dealt with?-- Yes, I was certainly satisfied by the change in Dr Patel's manner towards me.

Yes?-- The actual clinical competence issue I think was reported to Dr Keating and Dr Miach was aware of that as well, and I was satisfied that they had been informed and that they would take it further from there, yeah.

At the time that you went to see Dr Keating, would it be fair to say that you did not yet have the advice from Brisbane about the results of the angiogram?-- I can't exactly recall. I can recall that, obviously, having to transfer the patient to Brisbane, I had some anxiety about what their findings is going to be, and the very next day I did phone to Brisbane to find out if their view concurred with my view. Obviously sticking my neck out like that, I was quite anxious that maybe I was indeed wrong, and I did phone and speak to the guys at the Royal Brisbane Hospital to see if they agreed with my view and was quite relieved when they did. So when I went - I cannot remember the exact sequence of days when I made that phone call and when I did see Dr Keating. I just don't have clear memory of that.

Okay. So you are not certain as to whether or not you had your meeting with Dr Keating before you had that conversation with Brisbane or whether it was after?-- I don't have a clear memory of that, no.

Thank you. You said in your evidence earlier - I think in answer to questions from Mr Atkinson - that you could accept Dr Patel's error of judgment, as it were, with respect to this patient because we're all human, doctors included, and we make mistakes, we make errors of clinical judgment from time to time, but that what struck you as being unacceptable was his behaviour to you when you tried to point out to him his error?-- That's right.

COMMISSIONER: And I had the impression, from your answer earlier, that worried you for two reasons: one was purely a matter of professional courtesy and professional demeanour towards one another, but also it gave you the impression that Patel was sticking to his guns with his wrong diagnosis rather than being prepared to talk about it and consider someone else's view?-- Yes, my impression was he didn't take - he didn't take well to being challenged.

Yes?-- And didn't take well to being pointed out that a mistake is made. And, yeah, I think that was a definite deficiency.

Yes.

MR DIEHM: Would it be fair to say that it was these attitudinal problems of Dr Patel's that were the focus of your complaint to Dr Keating?-- Yes, as I mentioned before, that would have been one of the thrusts of my talk with him, was his attitude, exactly, and also the exact sequence of clinical decision making. That-----

Had he just made the clinical error, but when you pointed it out to him, thought about it, reflected, discussed it with you and then accepted or suggested obtaining a further opinion from another doctor, behaved reasonably, in other words, in response to your comments, would you have complained to Dr Keating about his clinical error?-- No, I don't think I

would have laid a complaint, simply, as I have mentioned, that we're all human, we all make mistakes at some time, we all have lapse in judgment. But I think the important thing in any system is to set up a system of checks and balances where if a mistake is made, that there be a second and a third safety net to correct that mistake. I think that's very important. So if he would have accepted the fact he made a mistake, acknowledged that and said, instead of, "This is my decision and my opinion", and respected you, I think I wouldn't have made a complaint.

Doctor, when you had your discussion with Dr Keating, you have told us that you asked him the procedure for laying a complaint. Did he advise you at all that you could, if you chose to, lodge a formal complaint in writing?-- No. The main response was that he felt I should just discuss it with Dr Patel first to make sure that there is no misunderstandings and to get Dr Patel's view beyond that. When I indicated to him that I wouldn't feel comfortable doing that, he then undertook that he would take it further with Dr Patel.

D COMMISSIONER VIDER: Could I just clarify, one of the other things that I understood you to say that the behaviour of Dr Patel, in terms of where the location took place of this conversation, namely the foot of the patient's bed, you also found distressful?-- That's correct.

And that's been subsequently borne out by the fact that it is your understanding that this particular patient has now chosen to go to Brisbane for a further procedure on the basis that that patient doesn't have any faith now in the Bundaberg Base Hospital?-- Yes. When I saw him when he came back from Brisbane and I saw him at outpatients department, he very clearly indicated to me that he was aware of the arguing around his bed and I think that distressed him, and that did lead to his decision, his loss of confidence and trust in the hospital. He rather preferred to go to Brisbane for further investigation.

MR DIEHM: Dr Smalberger, I suggest to you that when you raised your concerns with Dr Keating, Dr Keating explained to you that you had a number of options as to how the matter could be progressed and my suggestion to you is that one of those options that he offered to you was that you could have - you could seek a meeting to discuss the matter between yourself and Dr Patel further; I take it that part of that proposition you agree with, that he did offer that suggestion to you?-- Yes, yes.

I suggest to you that he also offered the idea that there could be a meeting between the three of you, that is, Dr Patel, Dr Keating and yourself?-- I couldn't recall that, no.

You can't recall that?-- No.

And I suggest to you that he also offered to you the option of putting a formal complaint in writing about Dr Patel's conduct?-- No, I cannot recall he making such a suggestion, no.

That I suggest to you that you, because of what you've described as being your concerns about confrontation with respect to Dr Patel, that is, you're not the confrontational type of person, there was further discussion between you and Dr Keating as a result of which you agreed with or the proposition that Dr Keating could himself speak to Dr Patel about the concerns that you had raised?-- Yes, I agreed to that, yep.

And you were happy enough with the matter being progressed by that means?-- That's right.

Dr Smalberger, with respect to patient P51, just a couple of questions concerning him directly. Firstly, is it right to suppose on the description of things as you've given them here, that in terms of your actual confrontation with Dr Patel and the interchange that went between you and he about what was going to be done with this patient, Dr Miach wasn't involved?-- He wasn't involved at the time that it occurred. He only became involved after I saw Dr Keating and Dr Keating informed Dr Miach of the event and then Dr Miach interviewed Dr Patel as well as myself and that was when Dr Miach was involved.

Thank you. And finally, with respect to the patient's record, if I can just show you two pages, starting it's the one sheet, the one leaf.

COMMISSIONER: Just while that's being taken over, Mr Boddice, you were going to provide some photocopies I think which would form Exhibit 130. Has that been attended to?

MR BODDICE: That was done in the lunch hour and Mr Groth has those documents, I understand.

COMMISSIONER: I just wanted to make sure it's all in order.

MR DIEHM: Now, if we can go to the bottom of that page, feel free to look at the whole document, but just the final entry just starting down there is the entry because it goes over the page. Now, that's a note made by an RMO, a junior doctor?-- Probably resident Medical Officer.

Resident Medical Officer?-- Yep.

Thank you, and is that Resident Medical Officer part of your team?-- Is part of my team, yes.

Are you able to interpret for us what that note is please?-- It says "CT plan large perinephritic haematoma, no free intraperitoneal fluid".

Now, can you tell us what that means?-- Perinephritic refers to next to the kidney and haematoma refers to a blood clot, so in laymans terms that would refer to a large blood clot next to the kidney.

All right, thank you. And if we can go over the page please to the other side? Start at the top if we may. And this is a note continuing with the same doctor, apparently. It says "Discussion with Dr Patel, Younis and Smalberger. Consult the Prince Charles Hospital with Dr Fitzgerald. Dr Fitzgerald recommends discuss with Royal Brisbane cardiology due to general surgical coverage. Discuss with Dr Nicolai, Royal Brisbane Hospital cardiology Registrar. Recommend admission by general surgery to get a spleen sorted out first and they would consult. Discuss with Dr Nathanson surgical consultant." Can we just move up there? "Recommends operation at BBH, Bundaberg Base Hospital"?-- That's right.

"Too unstable for transfer referred to talk to Dr Patel." "Additional", presumably meaning additional note, "Phoned by Dr Patel, Dr Nathanson will accept patient, discuss with Royal Brisbane Hospital ICU senior Registrar (Ian) will arrange bed, flight arranged, Dr Nicolai informed." Now, just so that we can understand the context of all of this, can you tell us how that fits in with the management of this patient leading up to the transfer in your understanding of what happened?-- Yes. As I mentioned, Dr Patel was of the opinion that the spleen was ruptured and he wanted to take him to theatre for a splenectomy. I refused. There was then still the question of two differing opinions and whose was correct. My junior phoned Prince Charles Hospital telling them that I recommended transfer to Prince Charles for coronary angiogram but the surgeon at Bundaberg Base Hospital was concerned that there's a ruptured spleen, and Prince Charles Hospital then felt that in such a situation it would be better for the patient to go to Royal Brisbane Hospital because they have surgical coverage there in case there is something wrong with the spleen. The consultant on-call at the Royal Brisbane ICU then phoned back and said that he would rather have the spleen then dealt with at Bundaberg Base Hospital as it would be ill-advised to transfer a patient via air ambulance with a ruptured spleen.

COMMISSIONER: I'm sorry to interrupt you, but we've heard all

of that before, haven't we?

MR DIEHM: We have, but I'm asking you how it fits in particular with the final part of the note?

COMMISSIONER: Well, it seems to fit in perfectly, it's just a summary of what the other witness has said.

MR DIEHM: If I may ask this question.

COMMISSIONER: Yes.

MR DIEHM: Dr Smalberger, under the heading "Additional", the concluding note might lead to the inference that Dr Patel actually played a part in the final arrangements for the transfer of the patient to Brisbane; is that how that transpired?-- That's correct, yes.

COMMISSIONER: That's what I recalled earlier.

MR DIEHM: I'm sorry, yes?-- The consultant from Royal Brisbane Hospital phoned my junior asking that the splenectomy rather be done at Bundaberg Base Hospital if there is a spleen problem. My junior informed him that I'm refusing such a procedure and suggested then that the consultant at Royal Brisbane Hospital call directly to Dr Patel. He then did talk to Dr Patel. The details of that conversation is not known to me, but Dr Patel then did phone the - finally phoned my junior and agreed that the patient can be transferred to Royal Brisbane Hospital.

Thank you. My apologies Commissioner, if I've wasted some time.

COMMISSIONER: No.

MR DIEHM: In the circumstances, I won't ask for the note itself to be tendered.

COMMISSIONER: Look, I think it's probably a good idea if it goes in because on the worst view it's corroborative, on another view it helps explain testimony we've heard.

MR DIEHM: Very well, your Honour.

COMMISSIONER: So I'll have it marked as Exhibit 134.

MR DIEHM: I have nothing further, thank you.

COMMISSIONER: Thank you, Mr Diehm. If the attendant could bring that over? Sorry, I just want to note how to describe it, progress notes relating to patient P51 for the 23/12/03. I suppose that's relevant too because Mr Mullins I think was asking something about the dates and given that those notes are dated the 23rd of December 2003, fits in with your recollection of it was shortly before Christmas?-- Mmm.

Yes. Yes, all right, that will be Exhibit 134.

ADMITTED AND MARKED "EXHIBIT 134"

COMMISSIONER: Anyone else? Mr Boddice?

MR BODDICE: Yes, thank you Commissioner.

CROSS-EXAMINATION:

MR BODDICE: Dr Smalberger, my name's David Boddice and I represent Queensland Health. I want to ask you some questions about Mr Kemps' file?-- Right.

Do you recall you were shown Exhibit 132 which was the discharge summary and you pointed out that the doctor who had completed that was in fact a doctor that's under your control?-- That's right.

And in that discharge summary it was pointed out to you that there was a reference to the fact that surgery was going to be undertaken?-- Right.

Now, had you been consulted by Dr Nicholls in relation to that?-- Looking back at the file, I look to see if I in fact did any ward round at the patient's bed and was aware of that, and in preparing for this session, I saw that my junior did see the patient and made a note and there's no indication that I was present at the ward round. Usually, if a consultant is present at the ward round, they would put that on the first one, "W/R" and the consultant's name and at the entry there, it doesn't appear that I was at that ward round.

Mmm?-- And I think after, after Dr Patel's saw Mr Kemps, the decision was made and I think my junior definitely must have been aware of that and - but the discharge was made before I actually did another ward round at the patient's bed and then I definitely wasn't aware of that. The other question that crossed my mind was that if I was indeed aware of it, would I also have refused Dr Patel to go ahead with the surgery like I did the other patient, and it's, I think just a hypothetical question at this stage, but it's difficult to say now what I would have decided if I - when I was indeed aware of that, but I think from the notes that's made in the progress notes, it is very clearly documented there that my plan and instructions was that the patient to go down to Royal Brisbane Hospital for further management.

COMMISSIONER: Just to clarify that, you say you can't be sure on that hypothetical question whether you would have refused to let Mr Kemps undergo the surgery because as I understood

your earlier evidence, an oesophagectomy was within the range of appropriate treatments for this sort of cancer, it wasn't your preferred option but it was an acceptable option?-- No, my feeling was that Mr Kemps should not have had surgery.

Yes?-- And should have been dealt with either by radiotherapy, chemotherapy or a stent or a combination of those.

Very well. I think the point is that had the surgery been carried out confidently without the blood loss and so on that we've heard about, it could have been successful?-- Yes, from the evidence I've heard today, some oesophagectomies has been done successfully at Bundaberg Base Hospital by Dr Patel.

Yes?-- I wasn't aware of that not being employed in the surgical department myself, but purely just on the clinical information I had in front of me on Mr Kemps, my decision at that time was that he should be transferred down to Royal Brisbane Hospital.

And you've already told us you were very strongly of that view, it wasn't just a line ball judgment, you really thought that the only-----?-- Yes, I think his progress notes in the file on two different dates reflect that decision was made for to have him transferred to Royal Brisbane Hospital.

Yes.

MR BODDICE: And doctor, I'll just have you have a look at the - I just have it opened, you'll see there's the bigger yellow stickers there if I can call them that. But one thing I wanted to ask you before we come to that, because an oesophagectomy can be a palliative procedure, can't it, in certain circumstances?-- It can be.

Whilst it's not going to cure the cancer, it is in order to have palliative effect for the particular patient?-- It's going to be a palliative effect in the sense that it can relieve the obstruction when food is swallowed even though it wouldn't prolong life, yes.

Doctor, if you have a look at the first Post-it note, if I can call it that, of the bigger ones, is that the note where you're referring to where your plan is, and this is a note of yourself and Dr Nicholls of doing a ward round and the plan was for a transfer to Royal Brisbane Hospital?-- That's right, that's what I'm referring to.

As you said, there's another note as well, could you turn over to the second Post-it sticker at the top there, that big one, do you see that? If you see on that page and the page before, that appears to be the note of the consultation by Dr Patel?-- That's correct.

And you'll see in that note there's actually a reference to a discussion as to what the options may be for the particular patient and the fact that chemotherapy was referred to or a

surgical option was referred to?-- Yes, it says here, "Long discussion with patient and wife regarding" something "and surgical resection verses palliative chemo and radiation.

All right. And it indicates what the choice was from the patient's point of view?-- The next paragraph reads, "Patient wants to proceed with surgical management".

Yes. And on the following page, there appears to be a ward round note by Dr Nicholls?-- That's correct.

Acknowledging Dr Patel's surgical consultation, you'll see there it says that "With thanks for the surgical consultation?"?-- That's correct.

So it appears Dr Nicholls was certainly aware of what had been discussed?-- That's right.

Which would seem to sit with the discharge letter that is Exhibit 132 that was referred to about the surgical option?-- That's right.

But as far as you can recall, you weren't part of that ward round that day when it was discussed?-- That's right, I - if I was indeed present at that ward round, he would have written like on the other ward rounds he would have written my name as the consultant was present at the ward round.

Just to complete the matter because the discharge summary-----

COMMISSIONER: I'll reserve number 135 and you can provide us with the photocopy of that, Mr Boddice. How should I describe it?

MR BODDICE: It's actually a progress note of the surgical consultation between Dr Patel and Mr and Mrs Kemps dated the 14th of December; is that correct, doctor?-- Yes, Dr Patel did enter a note on the 14th.

And there's also then a following record also dated the 14th by Dr Nicholls; is that the case, the following one?-- That's correct.

So it would work out to be, it will be three pages, one full page double-sided.

COMMISSIONER: For present purposes I'll refer progress notes of Mr Kemps dated 14 December 2004 and that can be Exhibit 135.

ADMITTED AND MARKED "EXHIBIT 135"

MR BODDICE: I wasn't going to put in the earlier note about the transfer to Brisbane.

COMMISSIONER: Yes.

MR BODDICE: And that's the only matter?-- If I can raise a point? Looking through the file, it appears to me that Mr Kemps was discharged on that 14th, in other words, he was seen by Dr Patel on the 14th and then that followed with a note from my junior and then he was discharged that same day and I think that explains why I didn't have a chance to do a ward round.

And Exhibit 132 I think is dated the 14th as well being the discharge letter that is written by Dr Nicholls and then Mr Kemps re-presented, I think, around the 20th of December, I think it was for the admission?-- Mmm.

D COMMISSIONER VIDER: Dr Smalberger, I understand you're a physician and not a surgeon?-- That's right.

And I understand also that one of the options is an oesophagectomy where a patient has been diagnosed with carcinoma, but given the extent of the tumor that was evident on the CT scan, I think you've mentioned something like 40 centimetres by some other dimension.

COMMISSIONER: Four centimetres.

D COMMISSIONER VIDER: It was very long, I understand it.

MR ATKINSON: I think he said 40 centimetres down on the oesophagus but three centimetres long on the oesphagus.

D COMMISSIONER VIDER: My question was going to be given the size of that mass, would it have been unusual to have operated successfully on that tumor and you would have expected more - that it would have been a stent that they would have opted for?-- Yes, I think as you mentioned as a physician I'm not that knowledgeable or experienced on the exact management of oesophageal cancer. My role was more in this case to diagnose the problem and then to hand it over for further management. So I wouldn't like to speculate on exactly what management should have been done.

COMMISSIONER: Any re-examination?

MR ATKINSON: Just a couple of questions.

RE-EXAMINATION:

MR ATKINSON: The first one, doctor, you were asked questions by my learned friend Mr Deihm over here. One of the questions he asked you was if there was just a clinical error of judgment, you wouldn't have taken the matter to Dr Keating?-- That's right.

I understood what you meant in agreeing with that proposition was this: that if Dr Patel was seeing a spleen broken in two where you weren't, you wouldn't have reported him for that?-- Not necessarily, if he - if I would have accepted that if he acknowledged he's made a mistake and then accepted the viewpoint, the correct diagnosis and then I would have accepted that as well.

By the same token, if all that had happened in that exchange was that a surgeon had told you that something you said was the stupidest thing he'd ever heard, that by itself wouldn't have initiated your visit to see Dr Keating?-- Just repeat the question please?

If all that happened was a surgeon said to you, "Look, something you just said, that was the stupidest thing I've ever heard" that alone wouldn't have made you go to see Dr Keating either?-- That's a difficult question. Yes, I don't know quite how to answer that.

COMMISSIONER: It depends entirely on the context, doesn't it? You know, if it had been, "South Africa's going to win the test.", and he said, "That's the stupidest thing he'd ever heard", then it wouldn't go to a professional issue, but saying it about a patient in your clinical judgment?-- I think that's definitely unprofessional conduct, saying that at the foot end of a patient's bed within earshot of a patient, I think that's definitely unprofessional conduct without doubt.

MR ATKINSON: What I want to ask you in terms of clinical errors of judgment, are these the things that made you go to see Dr Keating: first, that he was a doctor interfering with your patient while he was in the radiology department; secondly, that when you had that discussion in the ICU, it was clear that Dr Patel had already prejudged the position because he came armed with an anaesthetist?-- That's right.

And thirdly, that he wanted to persist with the operation even after you explained that it would be a significant risk in terms of heart attacks to the patient?-- That's correct.

And they're all the things that you told Dr Keating?-- That's right.

And they're important because they put the client's life - sorry, the patient's life at risk?-- Yes.

And they show a lack of judgment and insight in the surgeon?-- Yes, that's correct.

One other question: with Dr Nicholls, can you tell us how senior that doctor is in terms of how much experience they had?-- Dr Nicholls worked under me as an intern. Intern is your first year after graduating with your medical degree. The interns at Bundaberg Base Hospital were actually seconded to us from the Mater Hospital Brisbane, they come up to Bundaberg Base Hospital for approximately a two months

rotation either in the Medical Department or the Surgical Department. So these are very junior doctors who have just graduated from university. They still need direct supervision by their superiors and their level of experience is little.

Right.

COMMISSIONER: And no-one would blame a doctor like Dr Nicholls who's an intern for not standing up to Dr Patel, for example?-- No, absolutely. I think as an intern you are very wet behind the ears and I think if the Director of Surgery indicates to you that he wanted to operate on a patient, you're not going to question that.

MR ATKINSON: You were asked questions by my learned friend Mr Boddice and you said that to him well, if I had been informed by Dr Nicholls about the plan to do an oesophagectomy, it's hypothetical whether I would have intervened as I did in the case of P51?-- That's right.

In terms of going back now and seeing what steps you would have taken, are these the reasons, and you just tell me whether I'm right or wrong, why you might have intervened: because this patient, Mr Kemps, he had problems that made him an unsuitable candidate for an oesophagectomy in terms of his renal problems, his age and the fact that the cancer might well have been metastatic.

COMMISSIONER: And his heart was enlarged as well.

MR ATKINSON: Yes, and his heart was enlarged?-- Yes, I think if I would have had a discussion with Dr Patel at the time, I would have very strongly stood on the point that the patient is to go down to Brisbane.

Can you think of any reasons why you might not have intervened if you were consulted?-- No, I think there wouldn't have been any argument from Dr Patel that would have swayed my opinion otherwise, no.

Thank you. May the witness be excused?

COMMISSIONER: Indeed. Thank you, thank you so much for your evidence-----

MS GALLAGHER: One moment please.

COMMISSIONER: Yes.

MS GALLAGHER: If the Commissioner pleases.

RE-EXAMINATION:

MS GALLAGHER: Given what you've told us about clinical

practice, doctor, did it occur to you that your patient, Mr Kemps, had been discharged without your knowledge prior - at any time prior to when he subsequently had done the surgery?-- Yes, it does appear that he was seen by Dr Patel, arrangements were set up for him to be discharged and re-admitted under the surgical team and that was done without my knowledge, yes.

COMMISSIONER: But you weren't aware of any of it at the time?-- I wasn't aware of any of it.

And it didn't even come across your radar, as it were, that your patient had been discharged without consulting you?-- Yes, I thought about that - that point. If - if a discharge was done on the 14th, on the 15th I would have done a ward round and I must have noted that Mr Kemps is not in the bed where he was yesterday.

Yes?-- And the only thing that I could think is that I - I must have accepted the transfer to Brisbane was done, as - as was our plan.

Yes?-- I must admit I didn't - I probably didn't question my junior as to exactly where Mr Kemps went, but our team plan was transfer to Brisbane. That was our very firm plan and my feeling, if I must look back now, I think that was what I must have been thinking when Mr Kemps wasn't in his bed the next morning.

MS GALLAGHER: That in fact your junior doctor had carried out your direction?-- Sorry?

Sorry, to finish what you're suggesting, was it the case if Mr Kemps hadn't been in his bed that morning you thought, or what you're saying is that your junior doctor had ensured that your clinical orders had been carried out and the patient transferred as required?-- That's right.

Can you tell us when you first found out that Mr Kemps had undergone surgery and how you found it?-- Oh, the same intern, Roy Nicholls, came back to me after Mr Kemps had died and was quite distressed. The young man - the young man said to me that he feels very distressed because he feel he send him to his death. He was very remorseful about that and I could see was very much touched by events that had occurred and felt that - he probably felt that he could have prevented that.

Thank you, Doctor. I have nothing further, Commissioner.

COMMISSIONER: Thank you. Doctor, as I was about to say earlier, we are most appreciative of your time and your coming here to give evidence. Thank you very much indeed and you're excused from further attendance?-- Thank you very much.

WITNESS EXCUSED

COMMISSIONER: Ladies and gentlemen, we will adjourn now. Does 9.30 tomorrow suit everyone?

MR DIEHM: Yes.

COMMISSIONER: Thank you.

THE COMMISSION ADJOURNED AT 5.02 P.M. TILL 9.30 A.M. THE FOLLOWING DAY